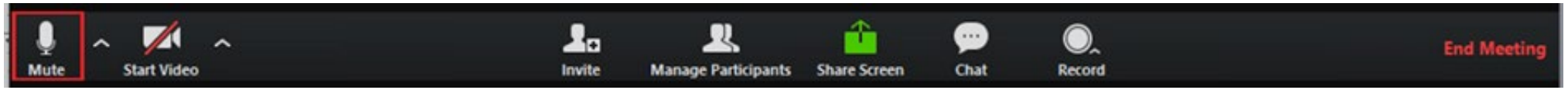
HEART HEALTHY OHIO INITIATIVE

HHOI Webinar

September 9th, 2022

Welcome and Logistics

- Welcome
- Please mute yourself when not talking
- Turn on video (if able)
- Chat in your name, organization, and role



Agenda

Time	Item	Presenter
12:00 PM	Welcome and Logistics	Stephanie Kanuch, MEd
12:04 PM	Review Key Driver Diagram and SMART AIM	Aleece Caron, PhD
12:05 PM	HHOI Dashboard Data	Jordan Fiegl, MS
12:15 PM	Run Chart Interpretation	Aleece Caron, PhD
12:30 PM	Timely Followup	Shari Bolen MD, MPH
12:45 PM	Teams In Action	QI coaches QIP clinics
12:55 PM	Next Steps/Wrap Up	Stephanie Kanuch, MEd

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Select Project Team Members

Case Western Reserve University at The MetroHealth System

PI: Shari Bolen, MD, MPH

PI: Aleece Caron, PhD

University of Cincinnati

PI: Saundra Regan, PhD

The Ohio State University

PI: Randy Wexler, MD, MPH

Quality Improvement Coaches

Caroline Carter, MS, LSW, BCC

Marty Williams, MS

Data Scientist

Jordan Fiegl, MS

Case Western Reserve University Project Management Leads

Stephanie Kanuch, MEd

Cathy Sullivan, MS, RD

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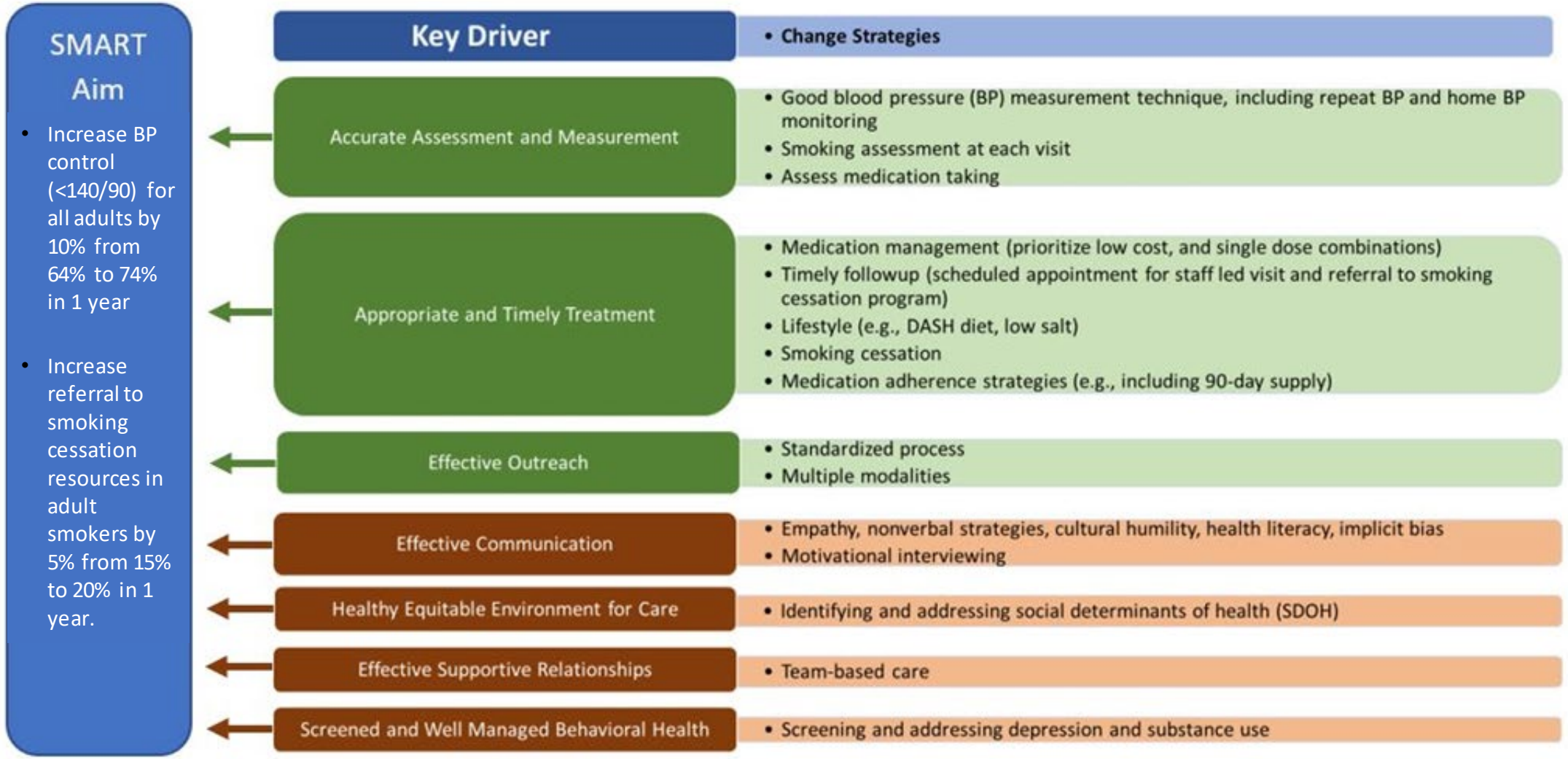
Key Driver Diagram and SMART AIM



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HHOI Data Dashboard

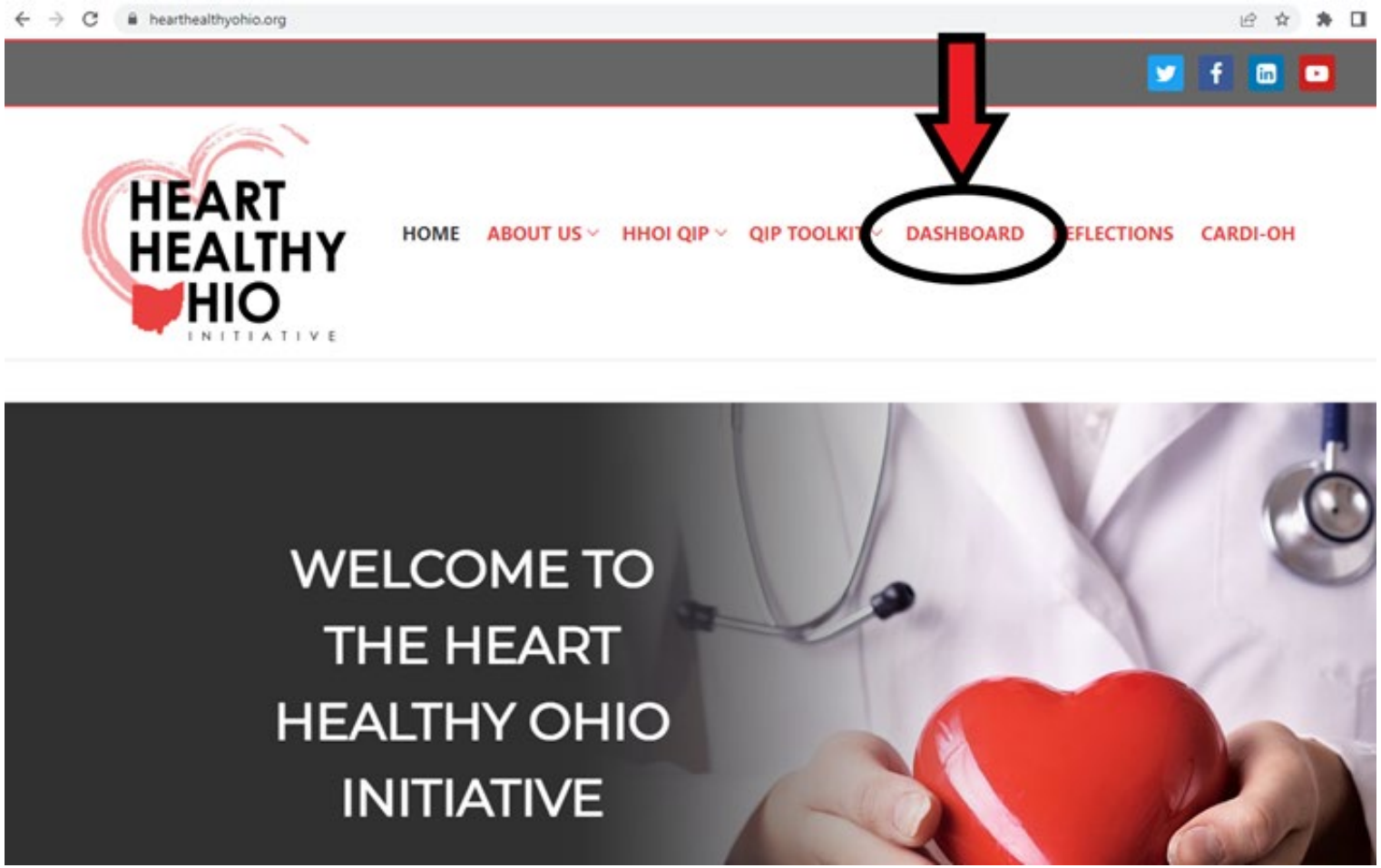
Jordan Fiegl, MS

Data Scientist

The MetroHealth System

Logistics of accessing your data

- Website: https://hearthealthyohio.org/

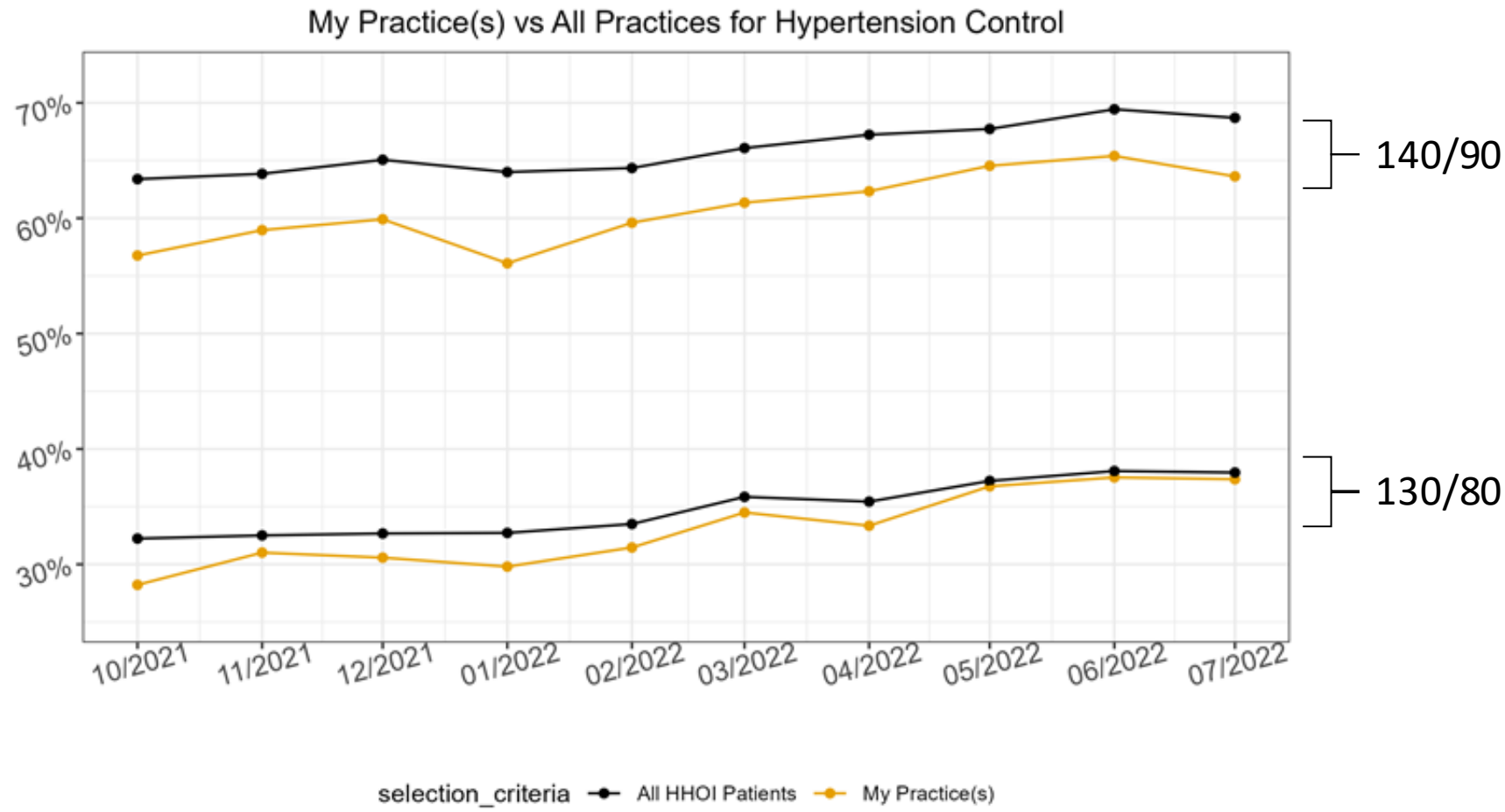


Logistics of accessing your data

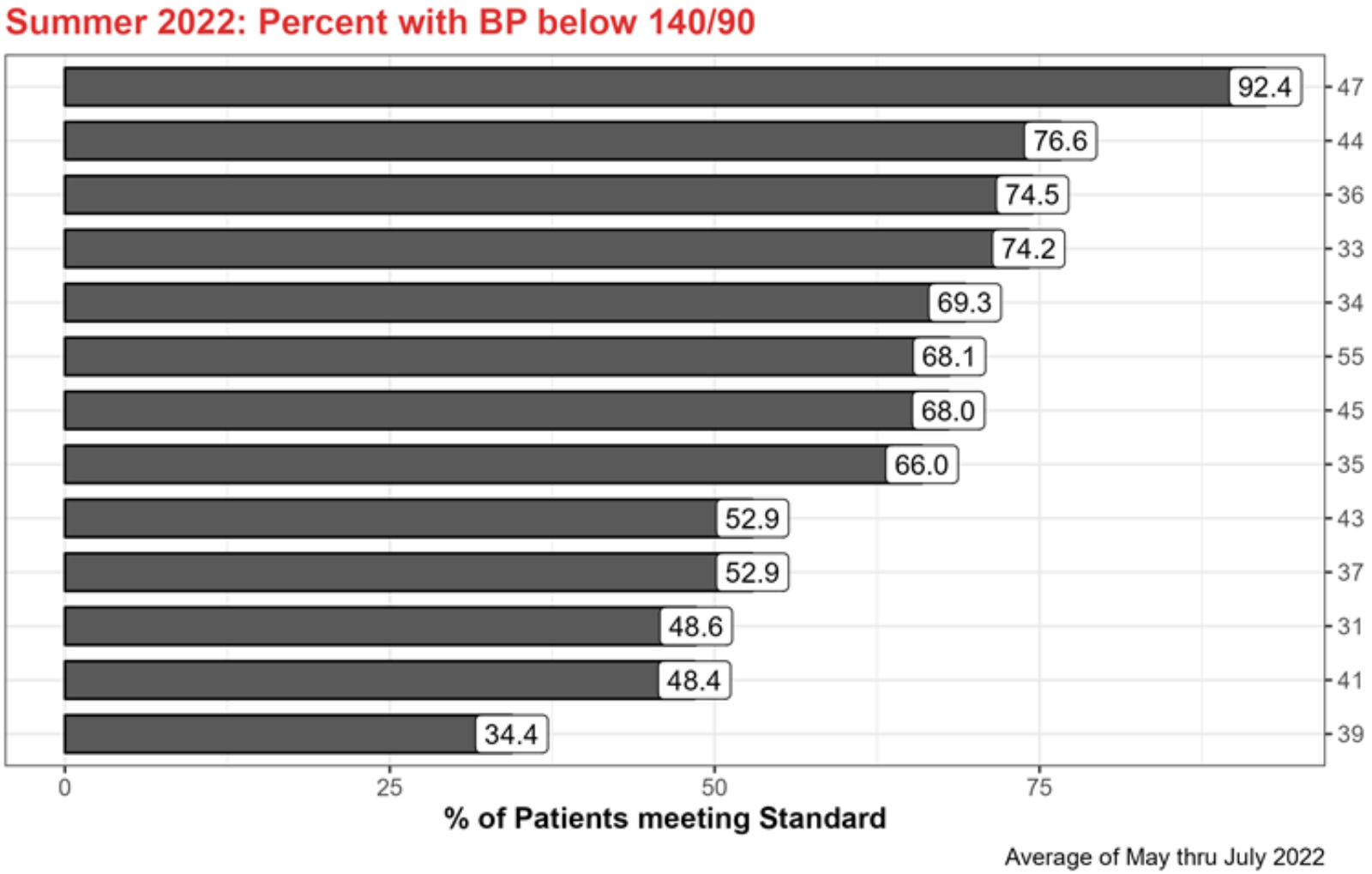
- If you do not see your practice in the slides, there are several possible reasons for this:
  - Still waiting on initial submissions
  - Baseline data has been received, but waiting on subsequent submissions
  - Processing complications on our side

- Please reach out to us through email if you are unsure of which reason you are not seeing your practice!

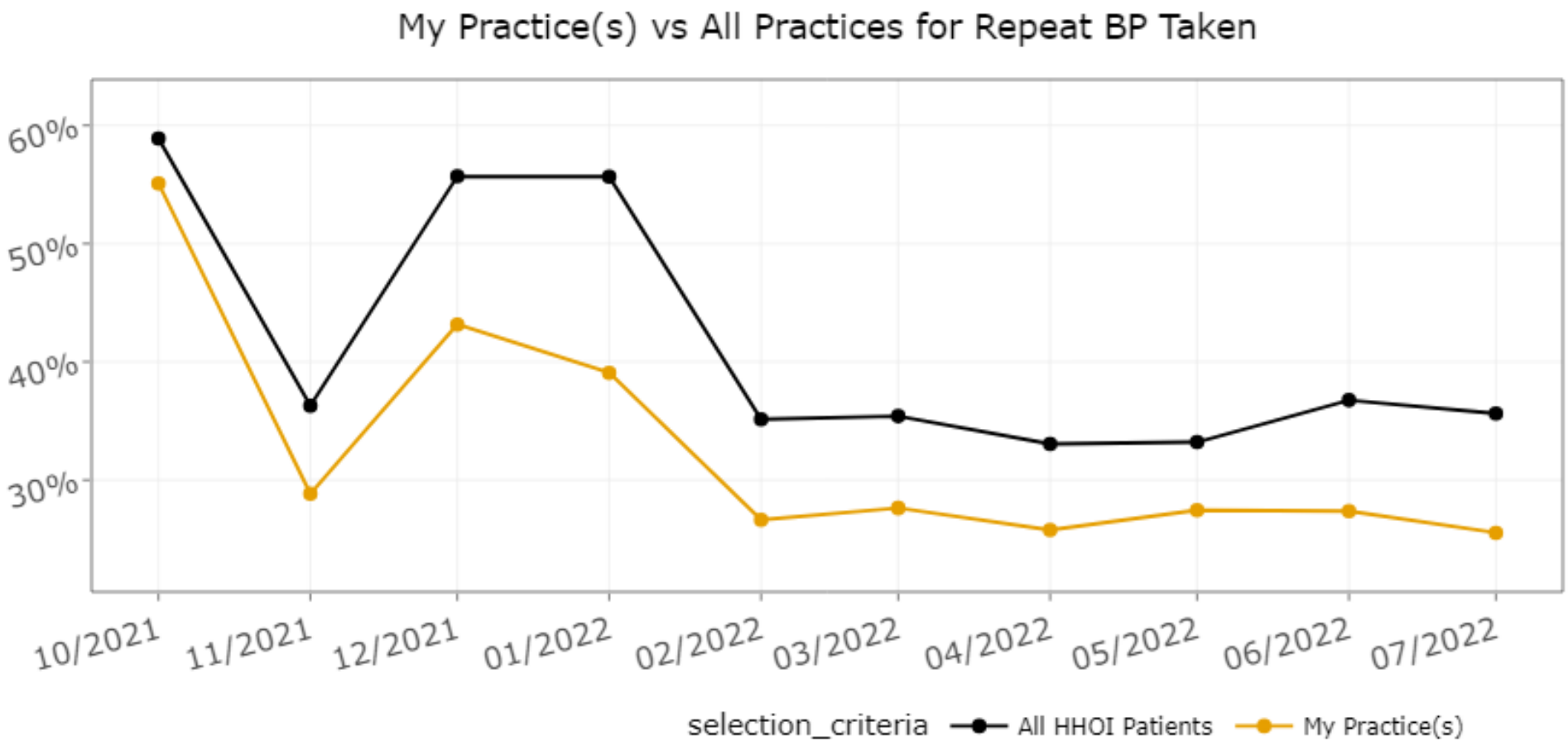
Percent of hypertensive adults under BP control by BP level



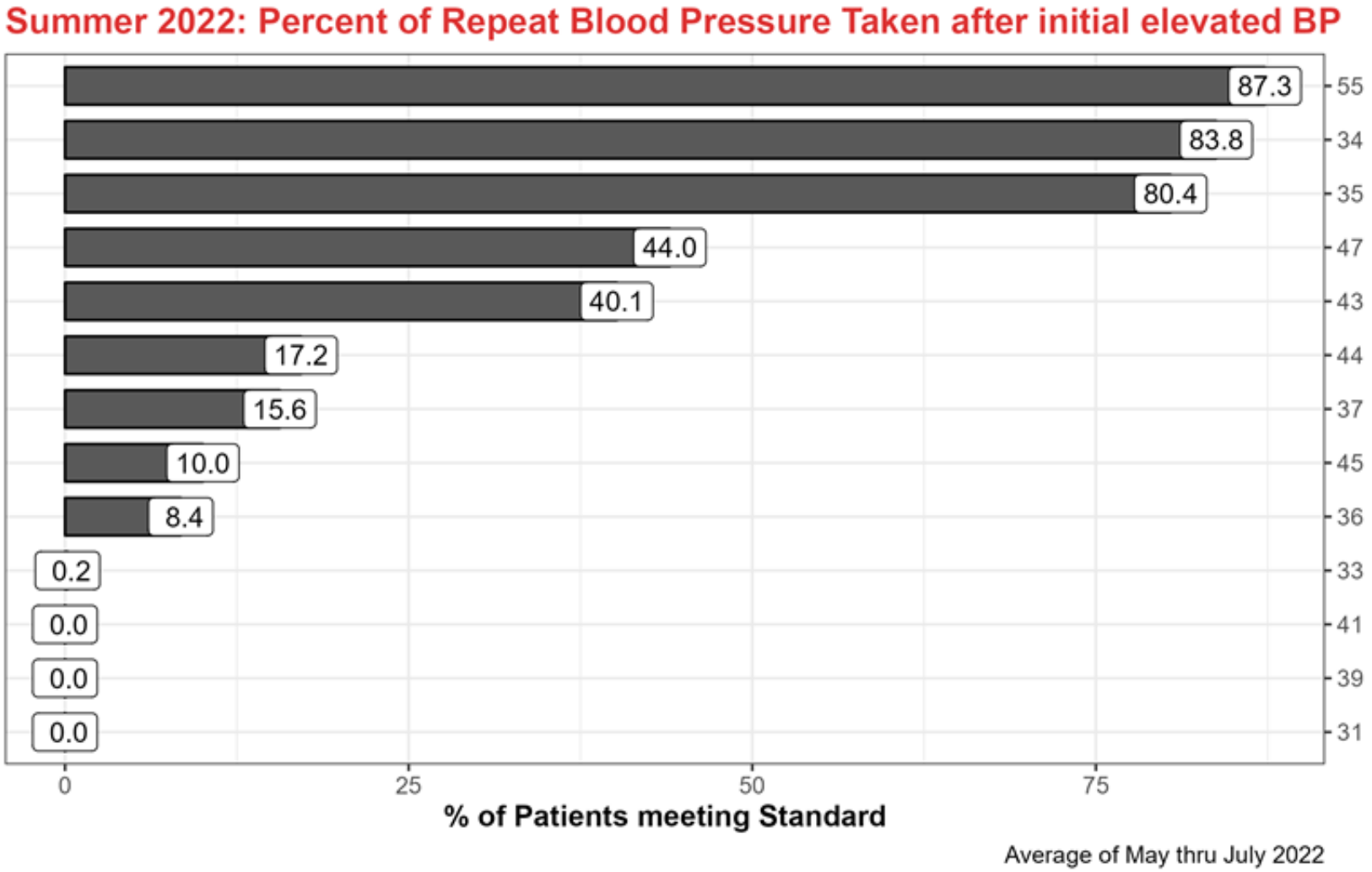
Percent of hypertensive adults with BP<140/90 by practice



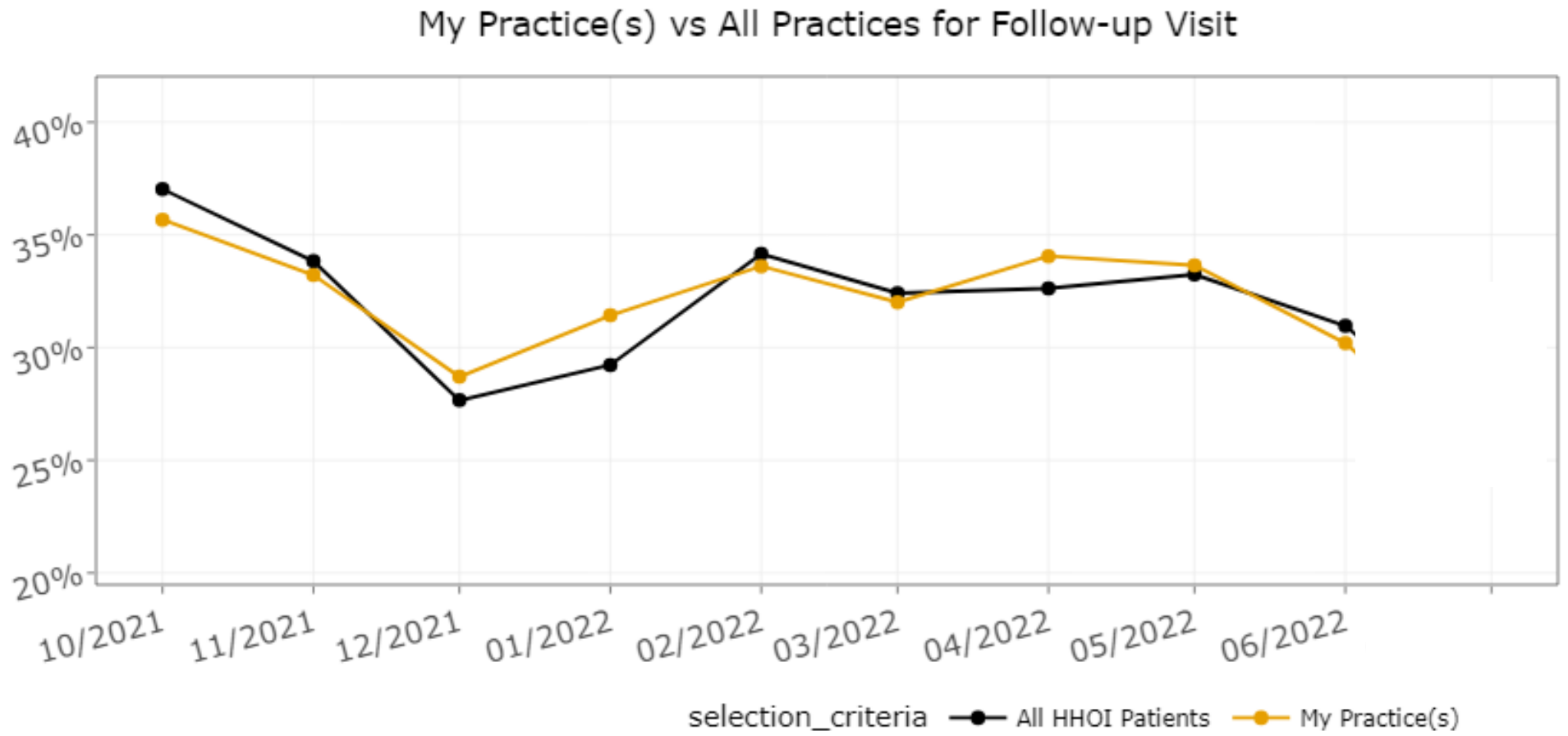
Percent of hypertensive adults with repeat BP if 1st BP elevated



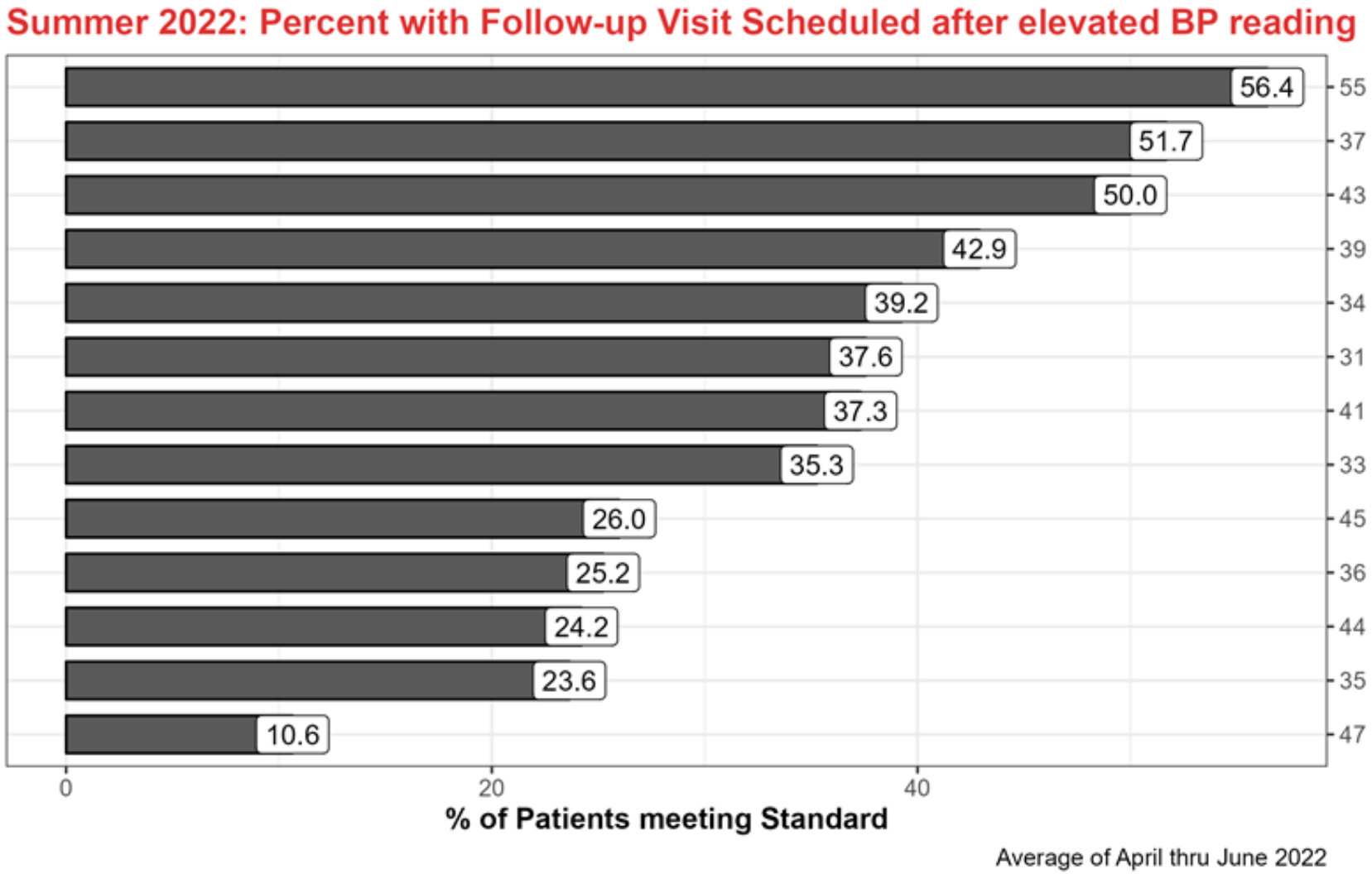
Percent of hypertensive adults with repeat BP if 1st BP elevated by practice



Percent of hypertensive adults with scheduled follow-up within 1 month



Percent of hypertensive adults with scheduled follow-up within 1 month by practice



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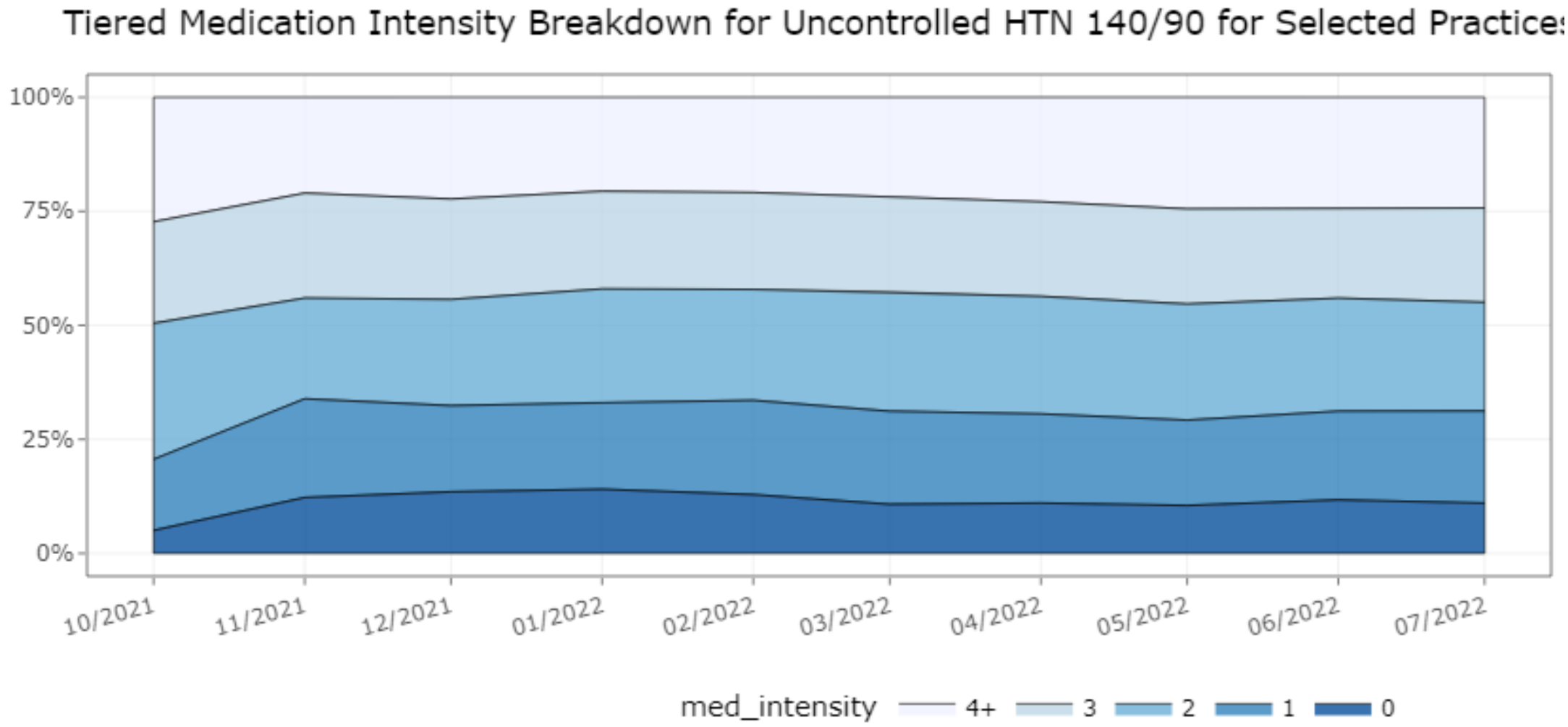
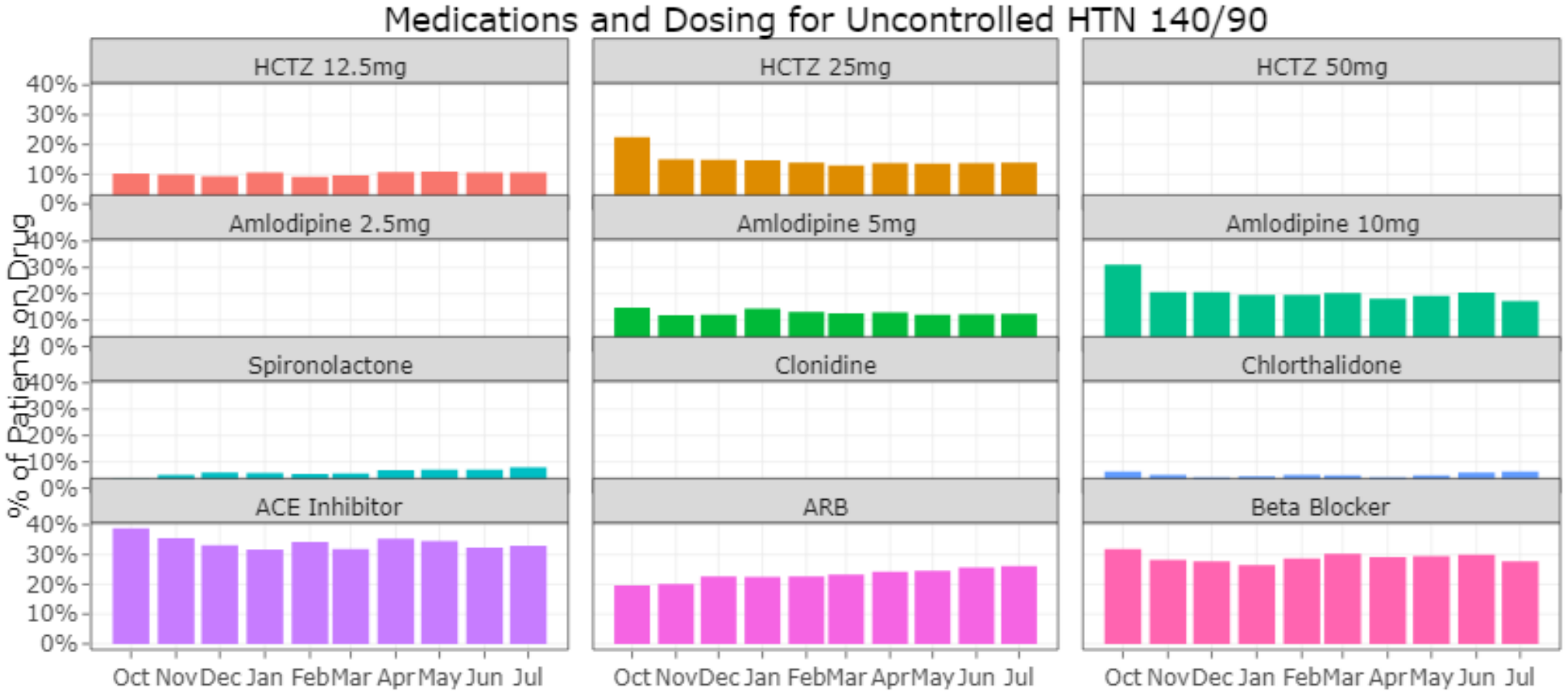
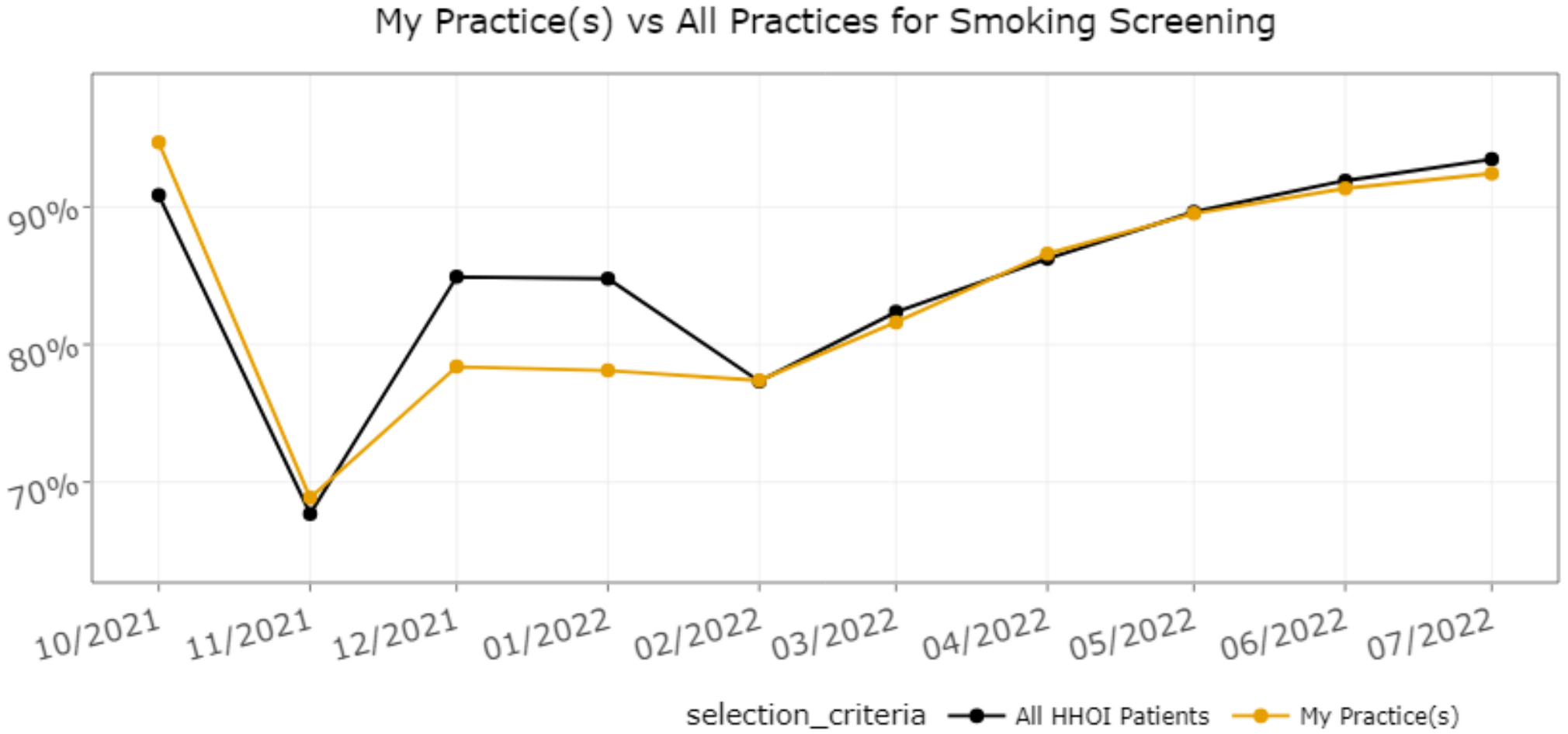
Percent of hypertensive adults with elevated BP on specific numbers of medications



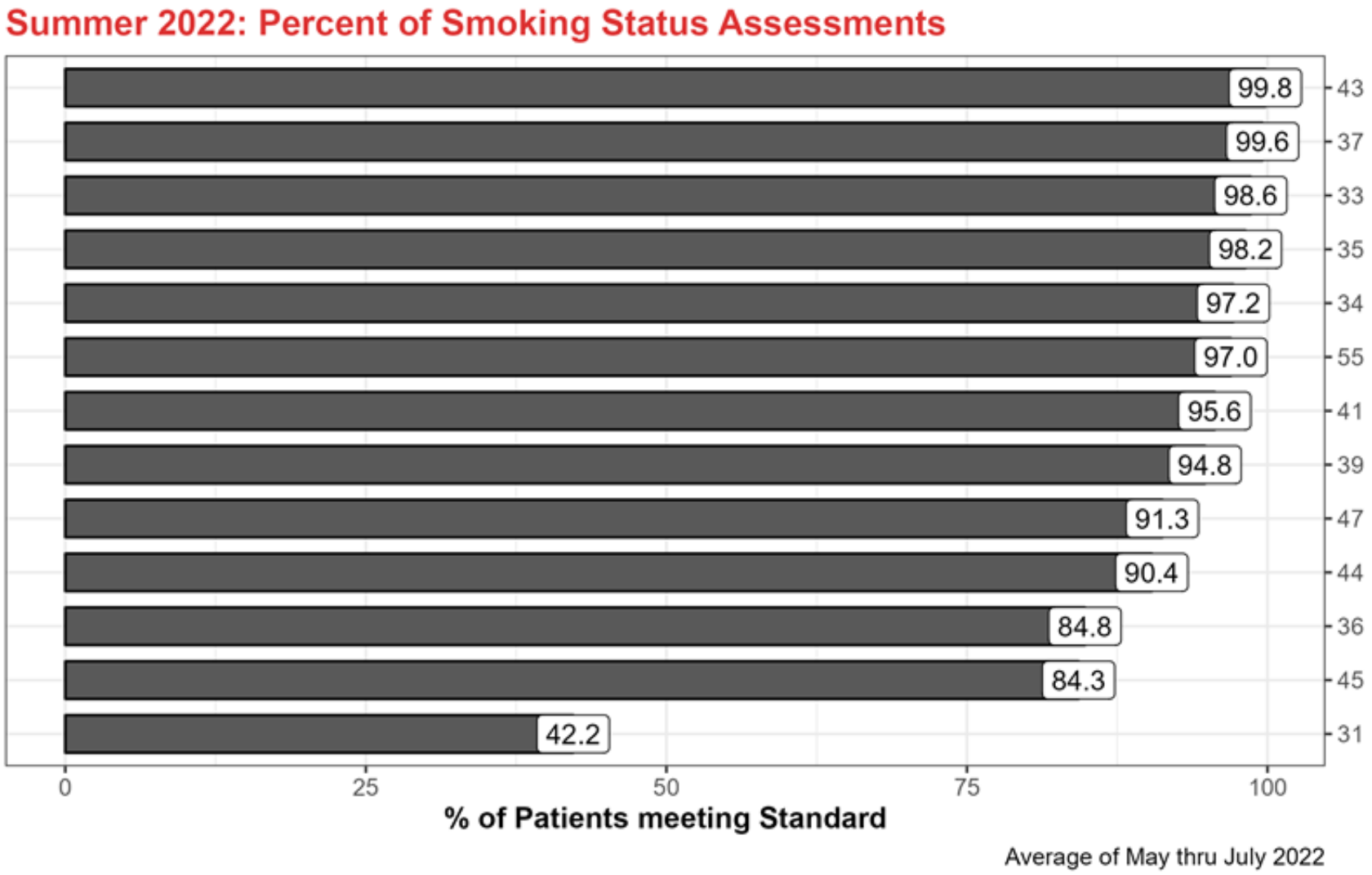
Percent of hypertensive adults with elevated BP on specific medications



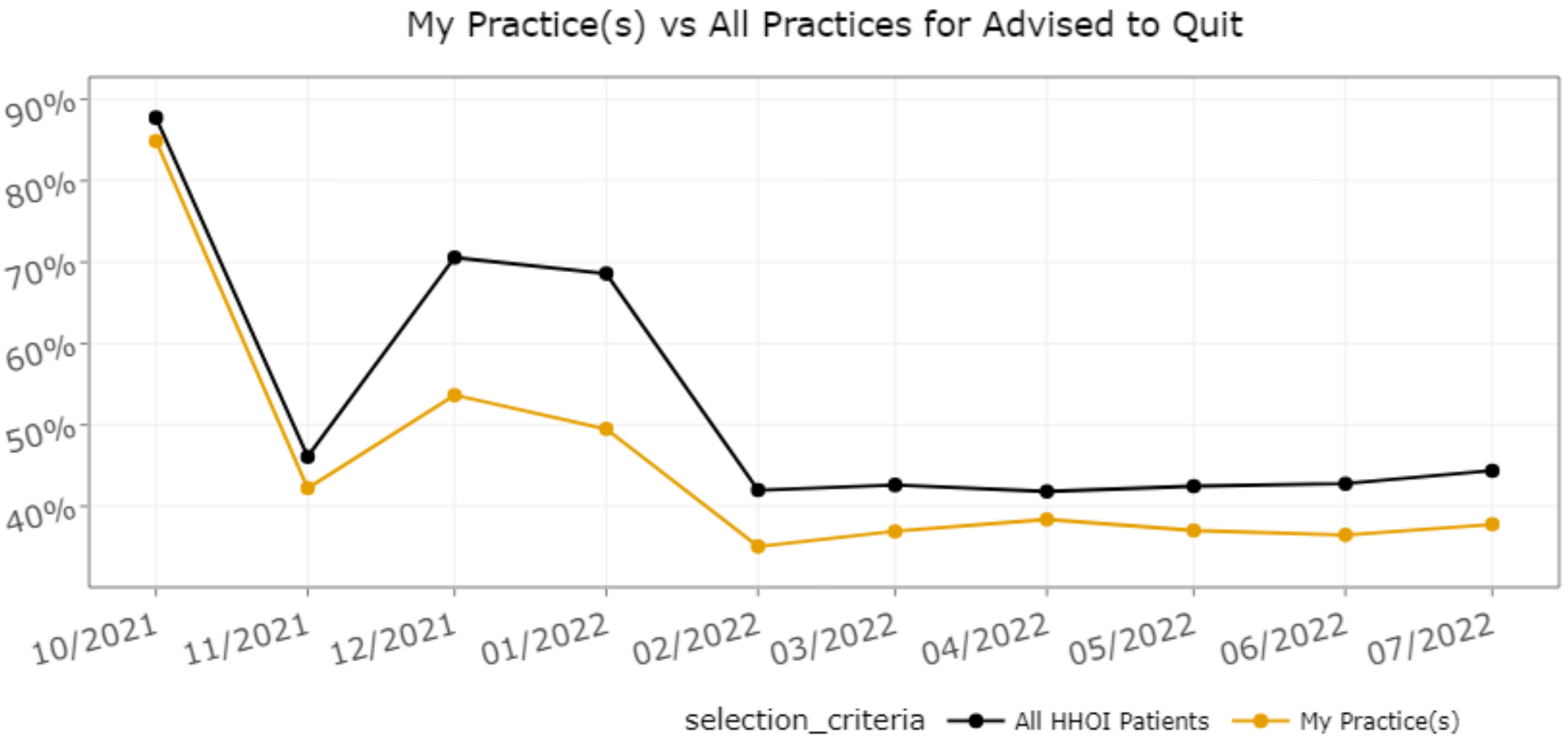
Percent of adults assessed for smoking in the last year



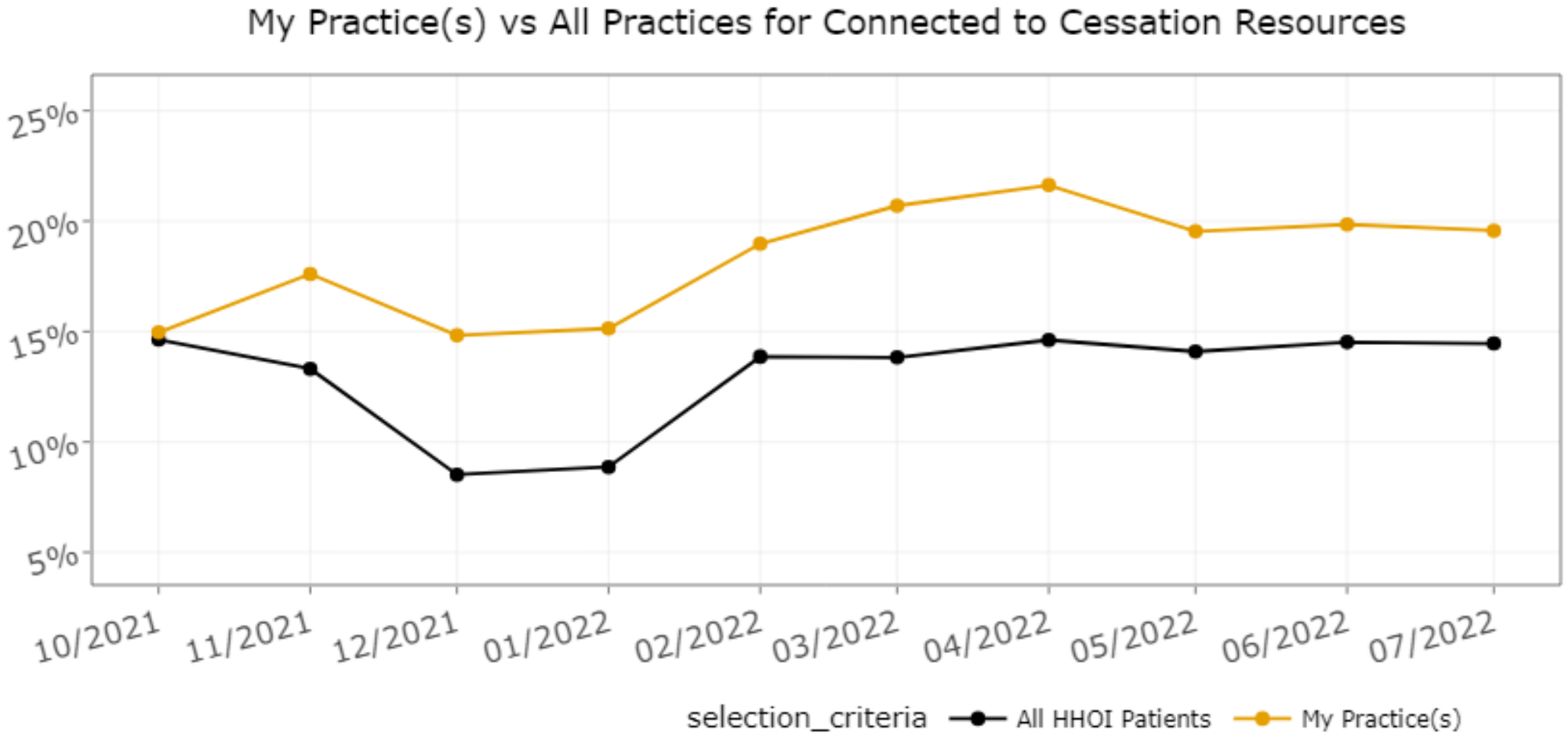
Percent of adults assessed for smoking in the last year by practice



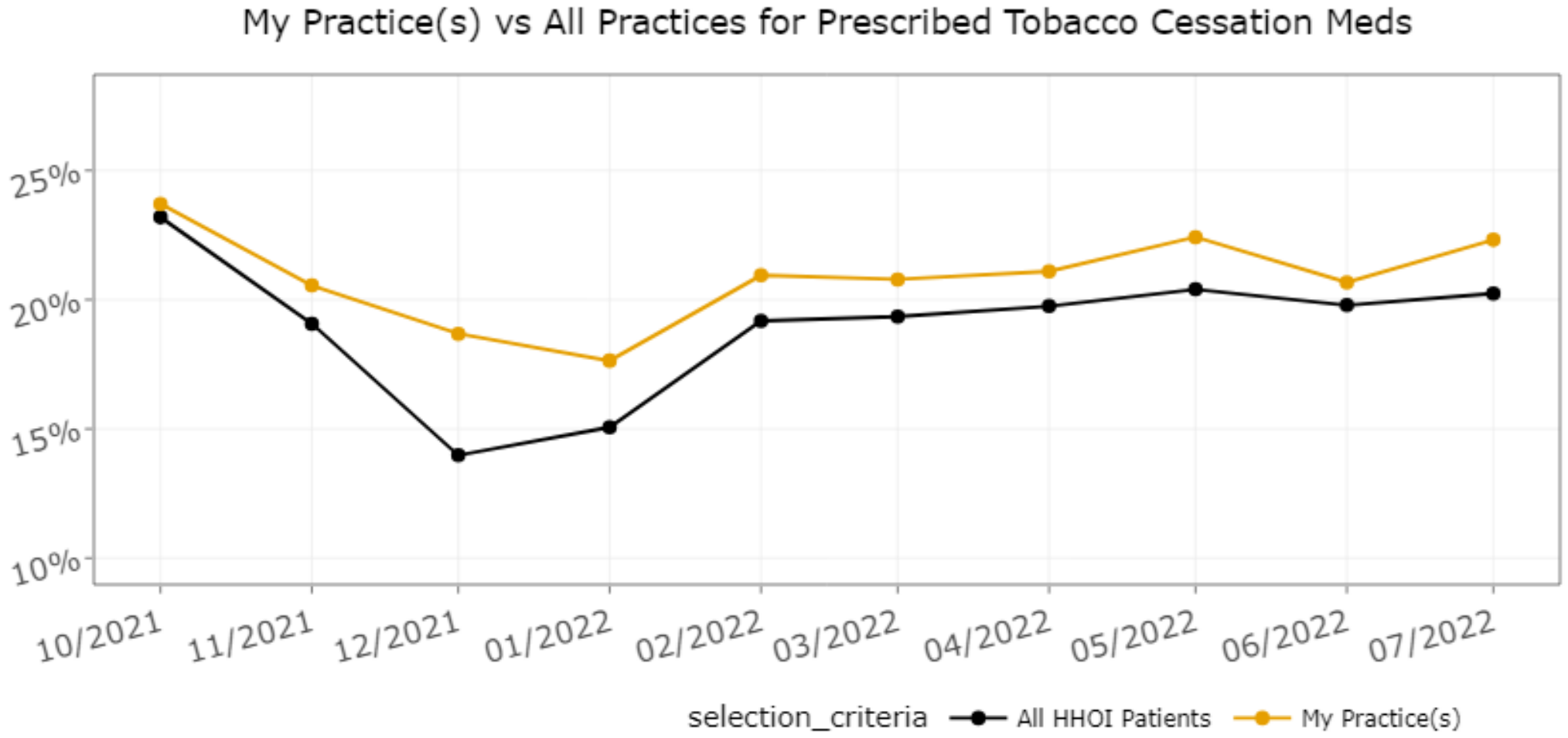
Percent of patient smokers advised to quit



Percent of smokers connected to resources for smoking cessation



Percent of Smokers Prescribed a Smoking Cessation Medication



Summary

- Opportunities exist for accurate BP measurement, timely followup, medication intensification, and referral to resources/medications for smokers
- Data reporting opportunities

Run Chart Interpretation

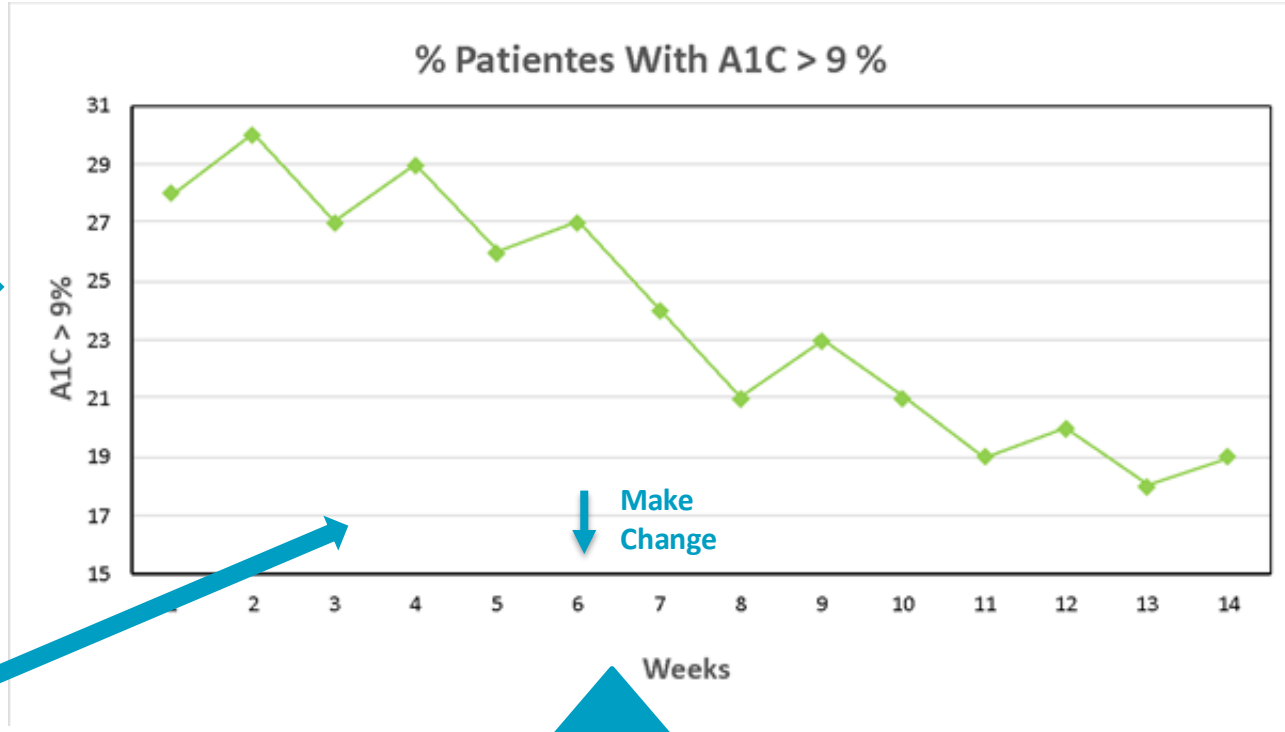
Aleece Caron, PhD

Associate Professor of Medicine

Case Western Reserve University/

The MetroHealth System

Why we use Run Charts?



- Make process performance visible
- Determine a change has resulted in an improvement
- Determine we are holding the gain

Langley, J. et al. The Improvement Guide. Jossey-Bass Publishers, 2009.

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Elements of a Run Chart

The centerline (CL) on a Run Chart is the Median

Median 4.5

$\tilde{x}$

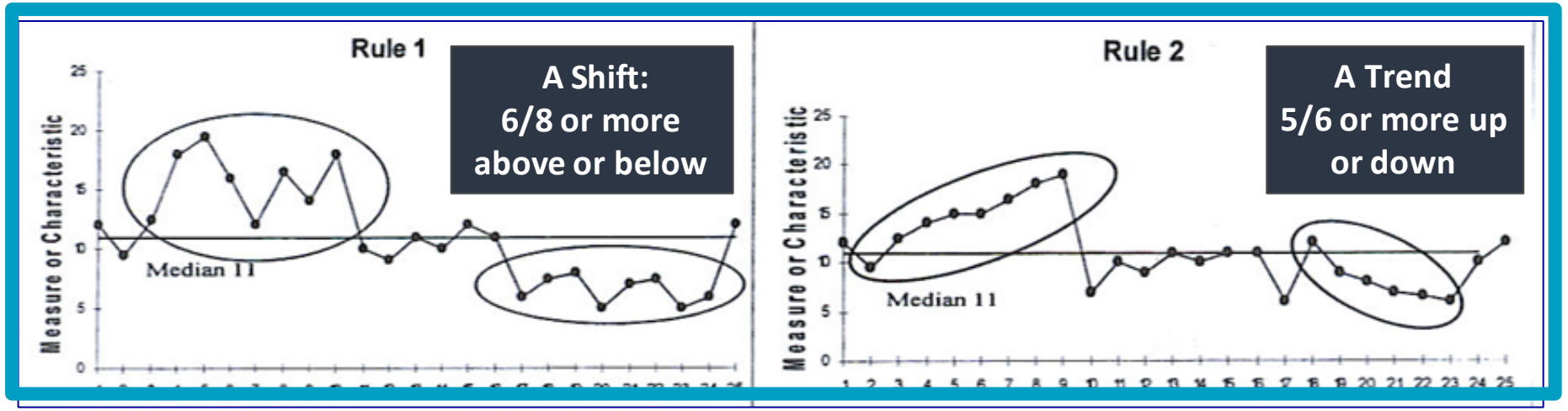
(CL)

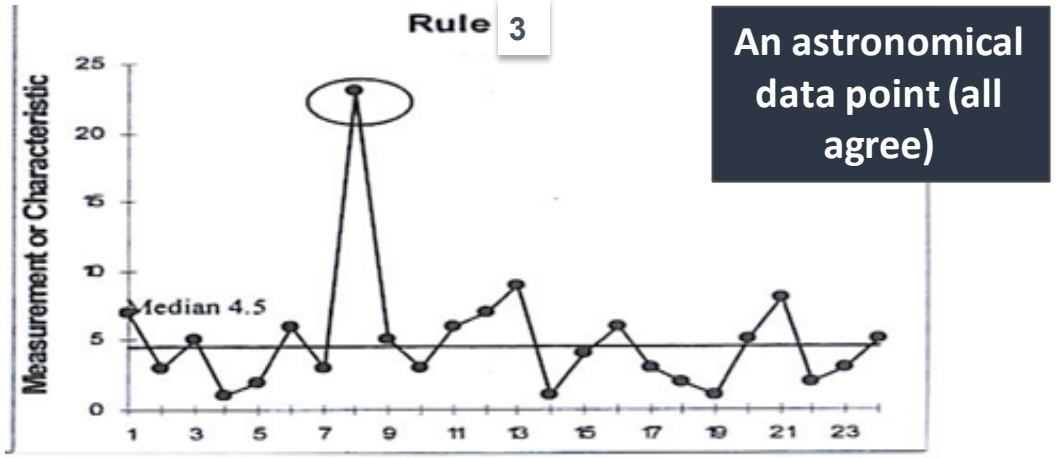
The Four Rules to Apply to a Run Chart

Four rules that indicate non-random patterns in a run chart, indicate SIGNAL!

1. Shift (6 above/below, use 8 if 20+)
2. Trend (5 up/down, use 6 if 20+)
3. Astronomical data point (all agree)
4. Too many or too few runs

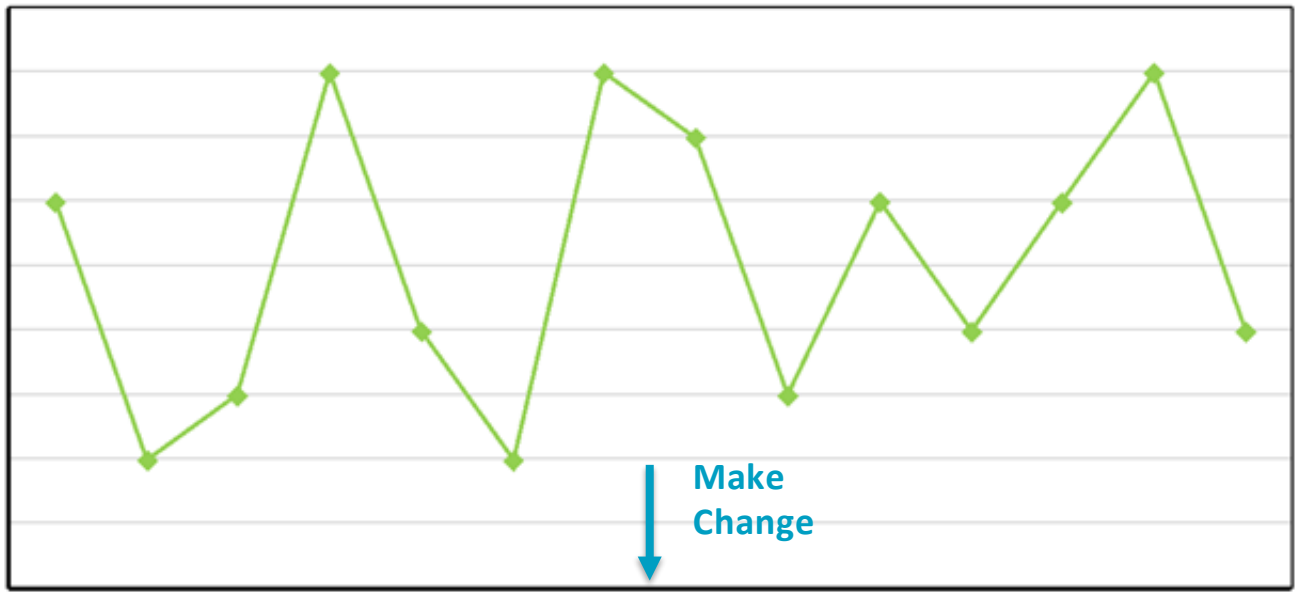
Run Chart Rules





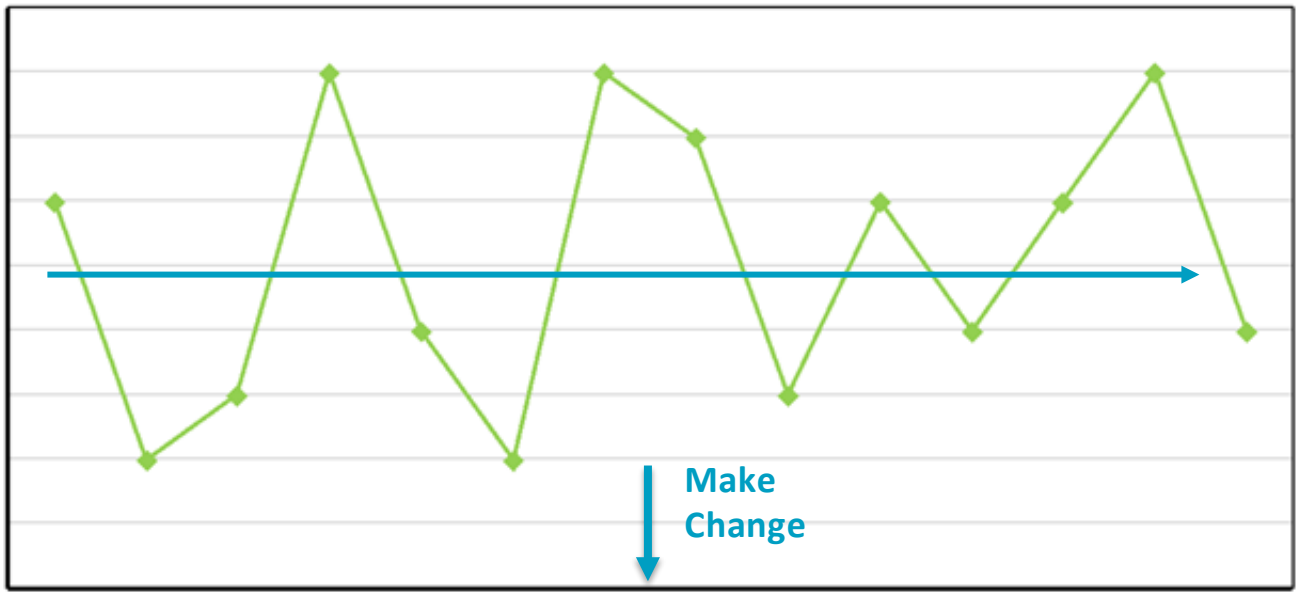
Adapted from The Data Guide by L. Provost and S. Murray, Austin, Texas, 2011, page 78

Case 1: Has There Been Meaningful Improvement?



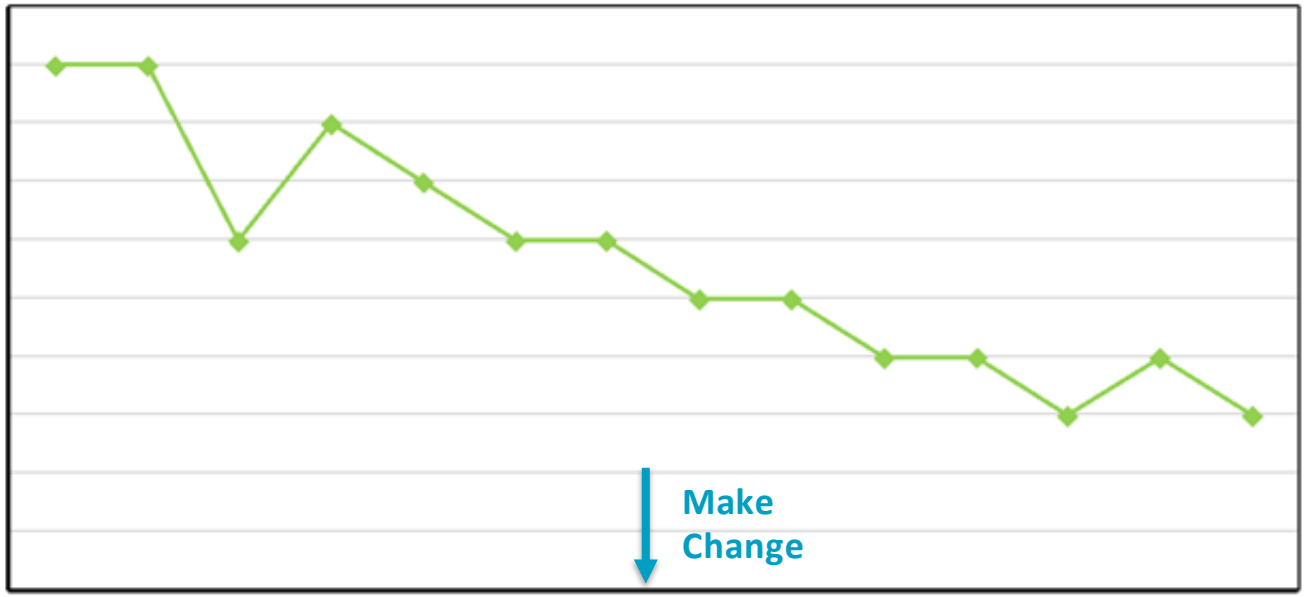
Chat in Your Answer!

Case 1: Has There Been Meaningful Improvement?



- No Improvement
- High variation
- Same results

Case 2: Has There Been Meaningful Improvement?



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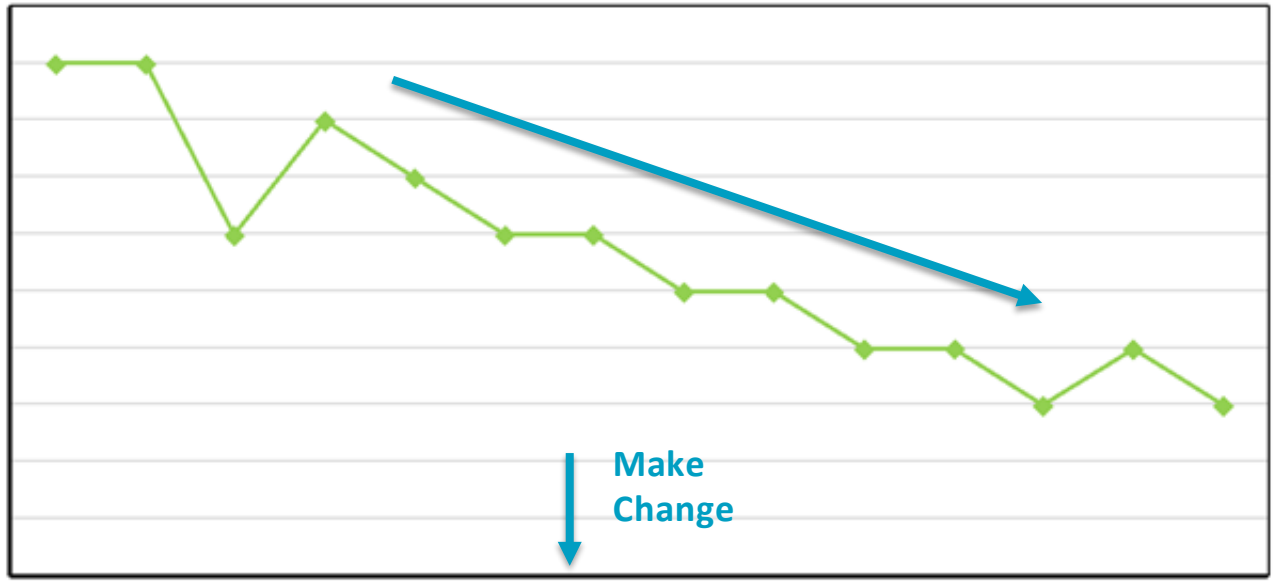
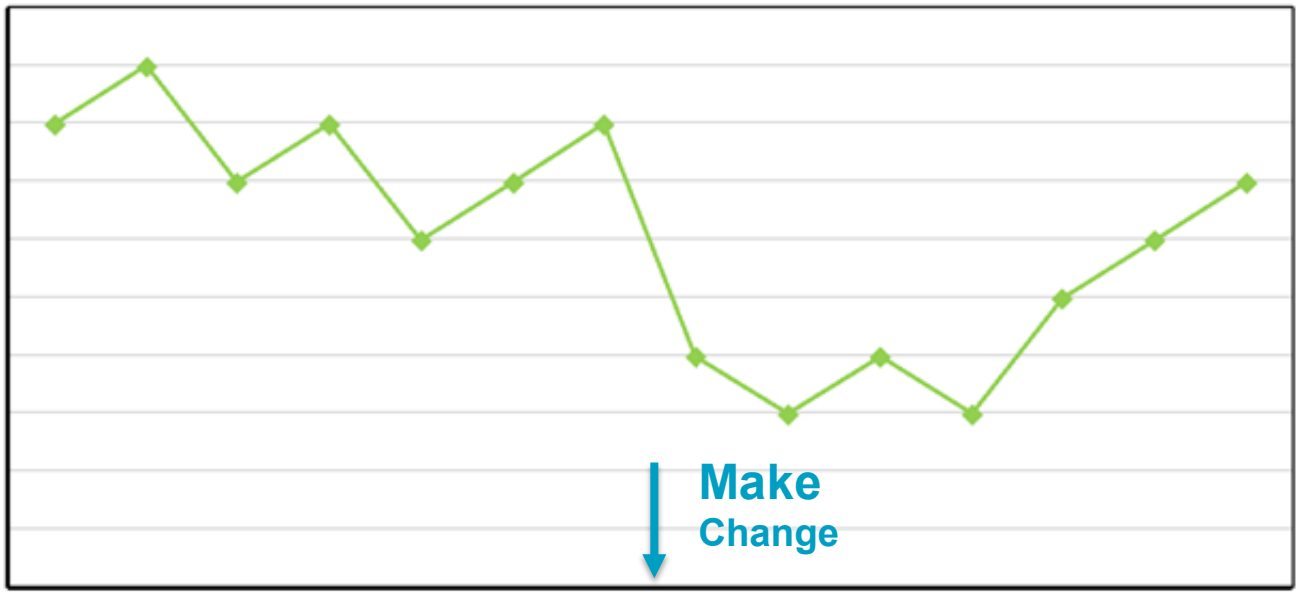
Case 2: Has There Been Meaningful Improvement?



- Improvement started before change
- Trend started before change

Case 3: Has There Been Meaningful Improvement?



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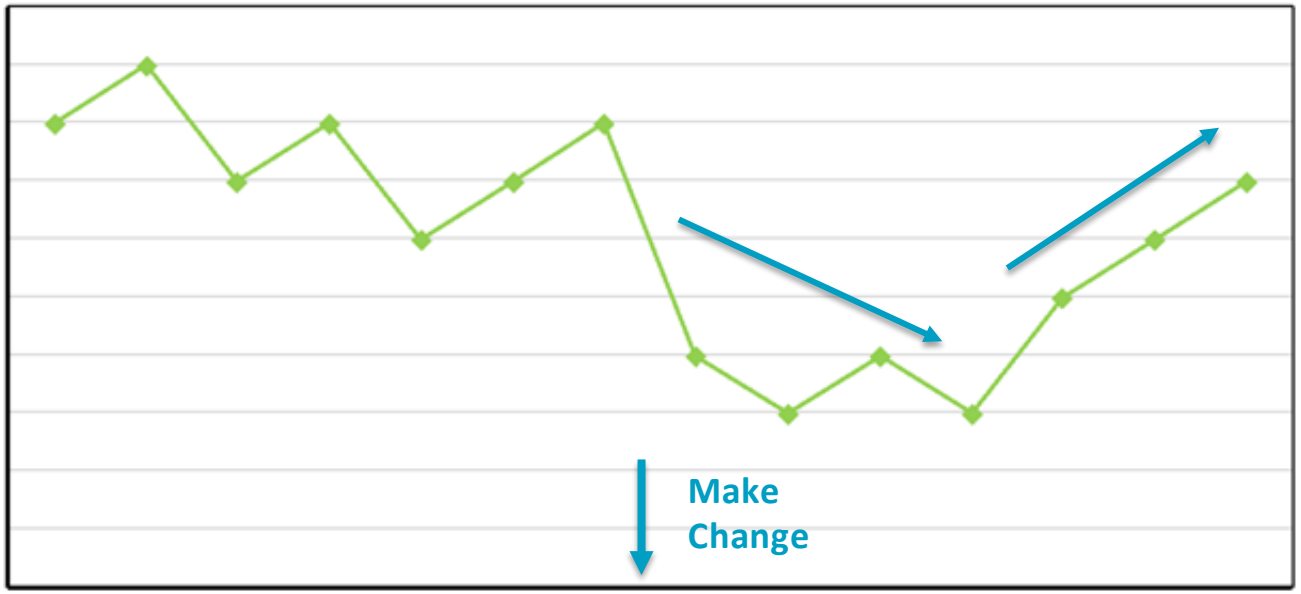
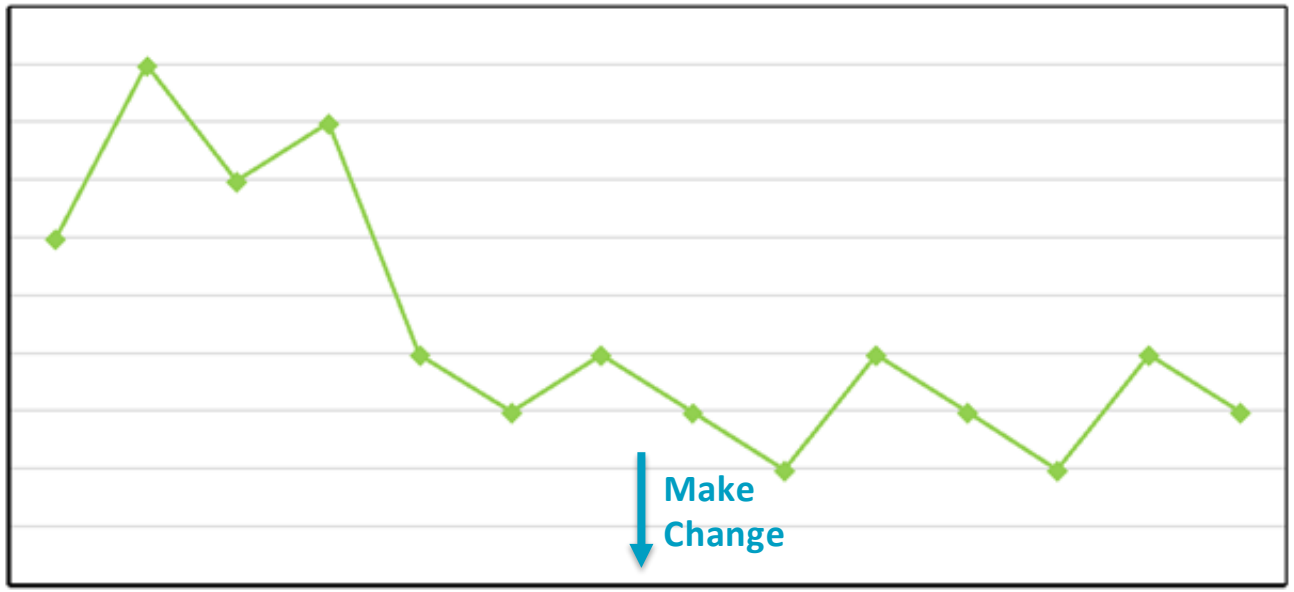


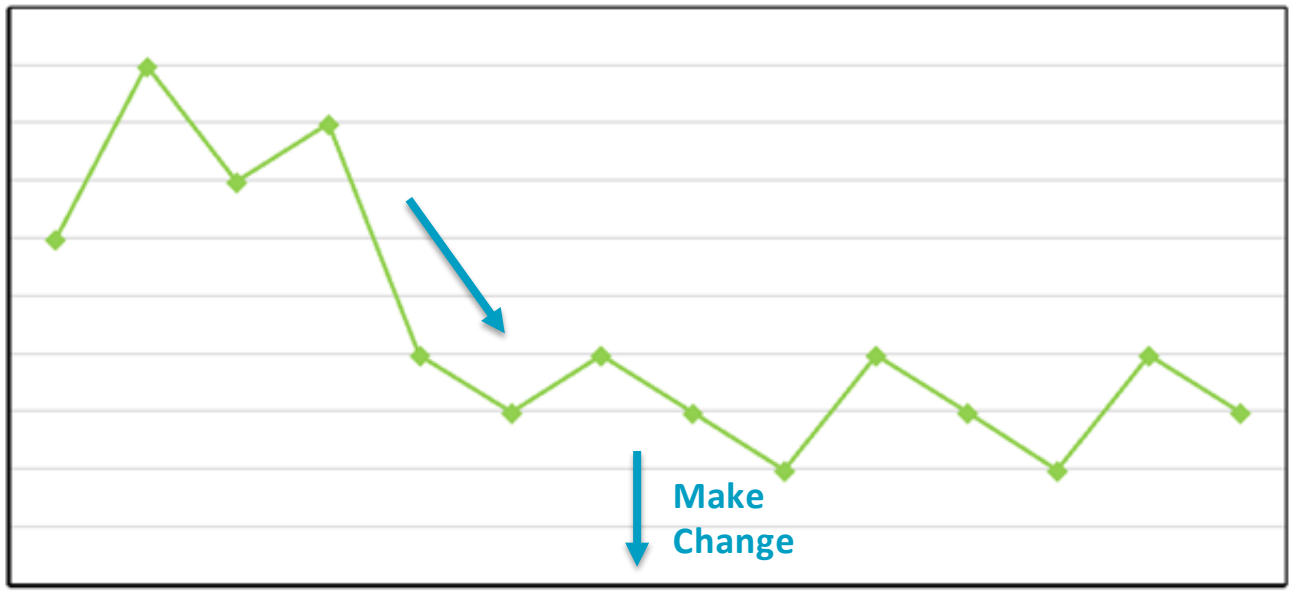
- Initial improvement
- Process went back to original behavior

Case 4: Has There Been Meaningful Improvement?



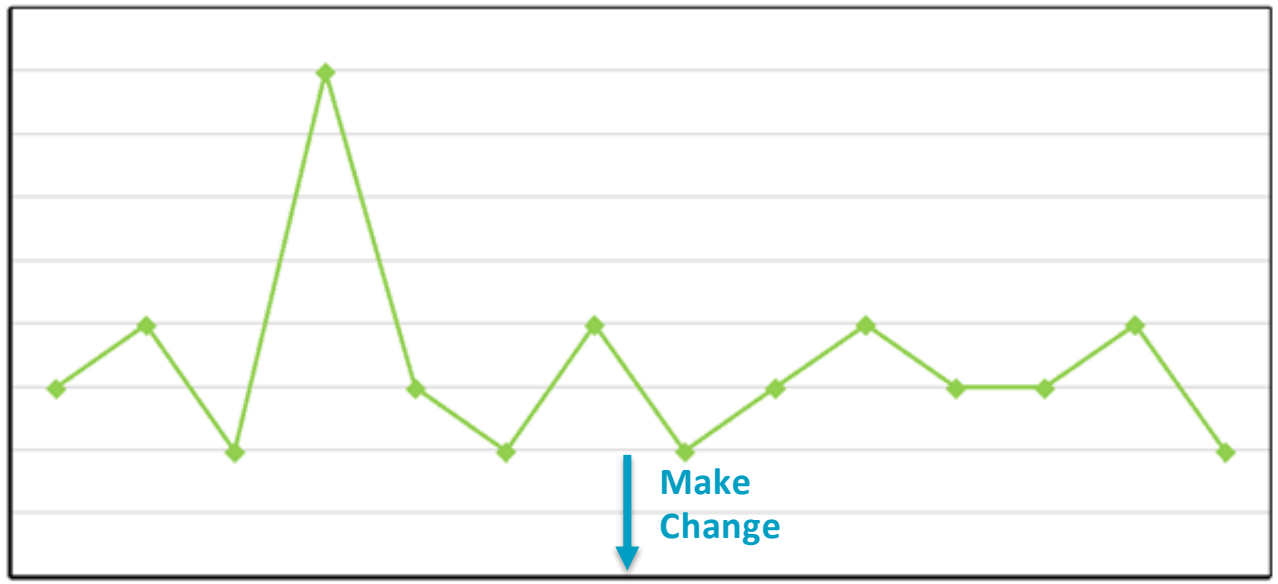
Chat in Your Answer!

Case 4: Has There Been Meaningful Improvement?



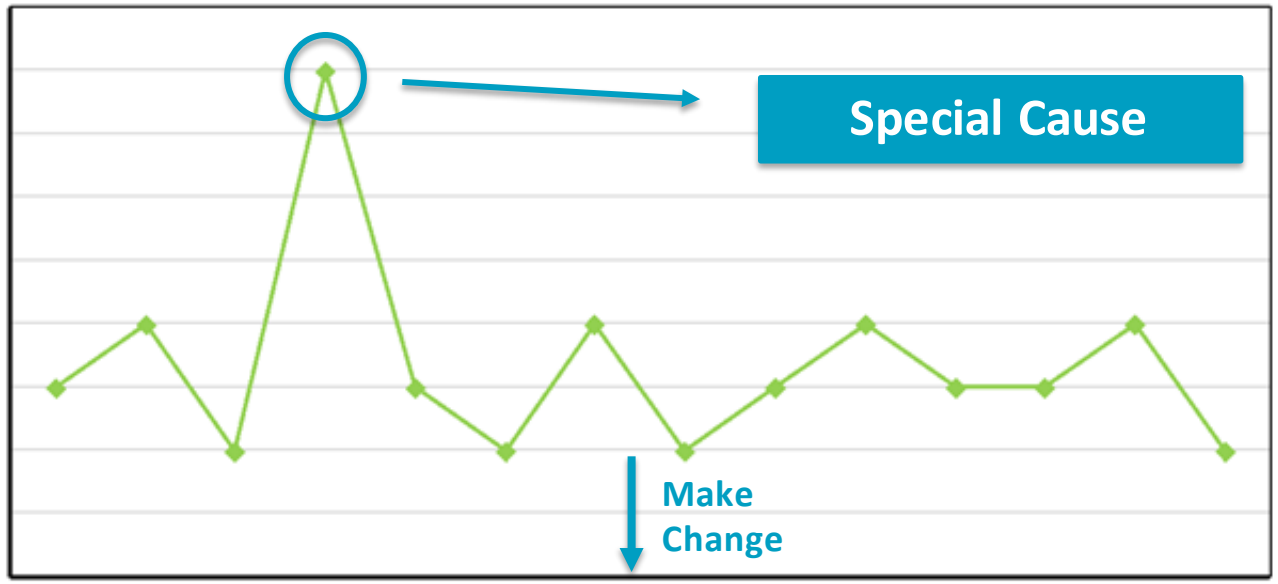
Improvement started in week 5

Case 5: Has There Been Meaningful Improvement?



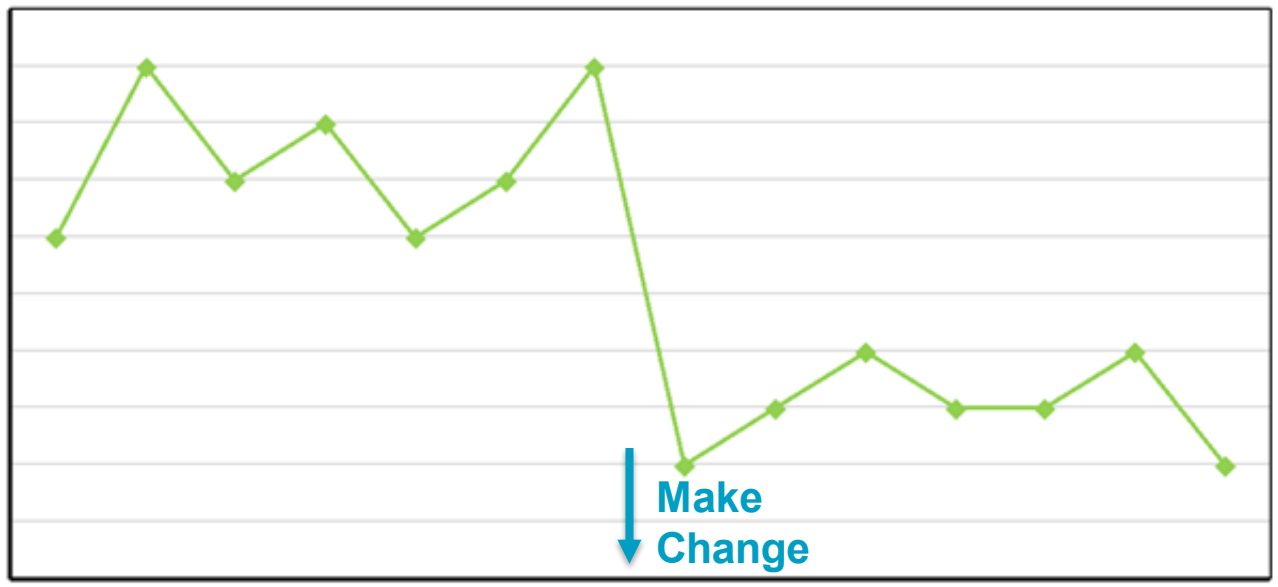
Chat in Your Answer!

Case 5: Has There Been Meaningful Improvement?



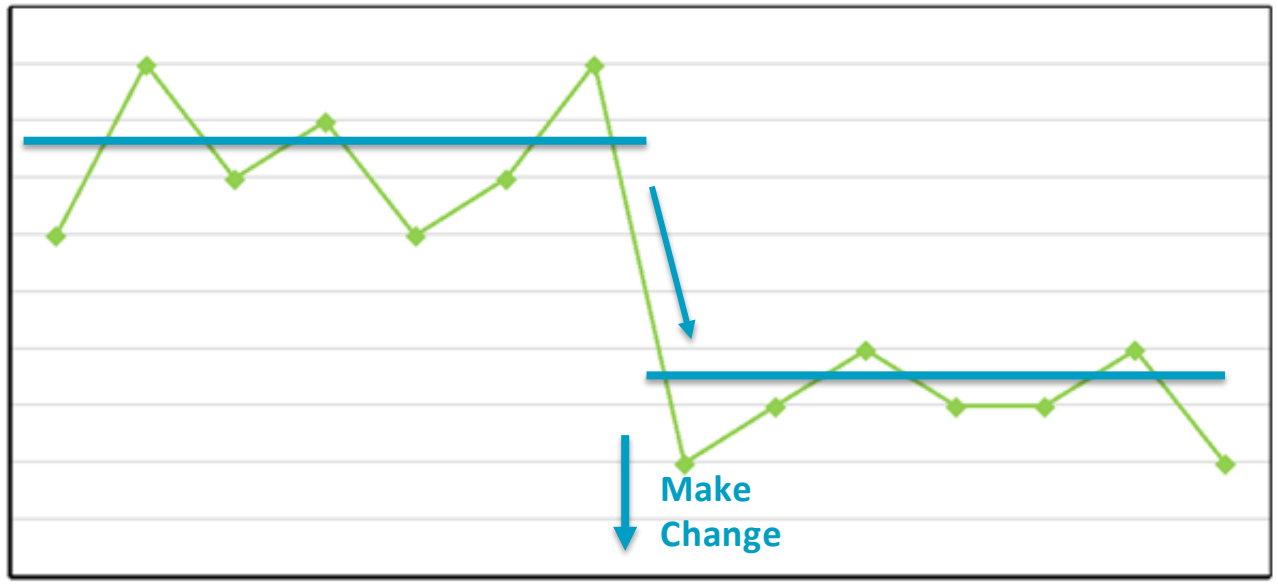
- No improvement
- Stable process

Case 6: Has There Been Meaningful Improvement?

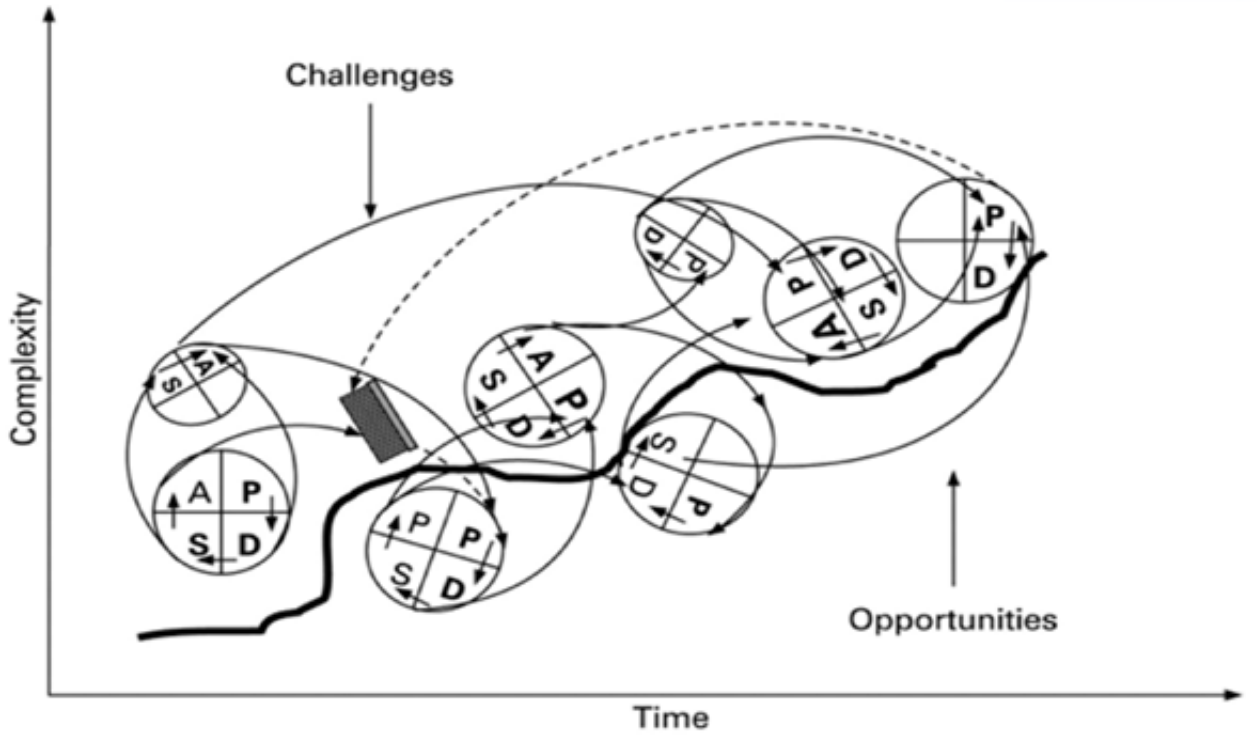


Chat in Your Answer!

Case 6: Has There Been Meaningful Improvement?



- Meaningful shift



Source: A case study of translating ACGME, to a comprehensive curriculum improvement projects as the key component requirements into reality: systems quality practice-based learning and improvement, A M Tomolo, R H Lawrence and D C Aron, *Qual Saf Health Care* 2009 18: 217-224

Standardized Office Procedures: Timely Follow-Up

Shari Bolen, MD, MPH

Professor of Medicine

Case Western Reserve University/

The MetroHealth System

Standardized Office Procedures (SOPs) and Checklists

- Assists in avoiding missed opportunities for improved health
- Minimizes disparities which may arise from implicit bias
- For this project, we encourage developing SOPs around accurate measurement, timely follow-up, and outreach for hypertension and smoking

Timely Follow-up Poll Question

What is the recommended interval for follow-up for an adult with an elevated BP reading?

1. One Month
2. Three months
3. Six months
4. Unclear
5. Don’t know

Why schedule followup within 30 days?

- Some literature suggests greater and quicker improvements in HTN control with more frequent follow-up
- Enhanced opportunity to engage with higher risk patients
- This should translate to improved outcomes over time
- Opportunity to also address other care gaps important for health
- Patients who smoke and are interested in quitting have expressed an interest in having followup by their providers

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Modeled after the Kaiser Hypertension Improvement Program

- Accurate measurement of blood pressure (BP)
- Monthly nurse or medical assistant-led visits until BP is controlled
- Treatment algorithm which prioritizes once daily low cost effective medications
- Outreach using EHR-based registries
- Enhanced communication focused on building trusting relationships with patients

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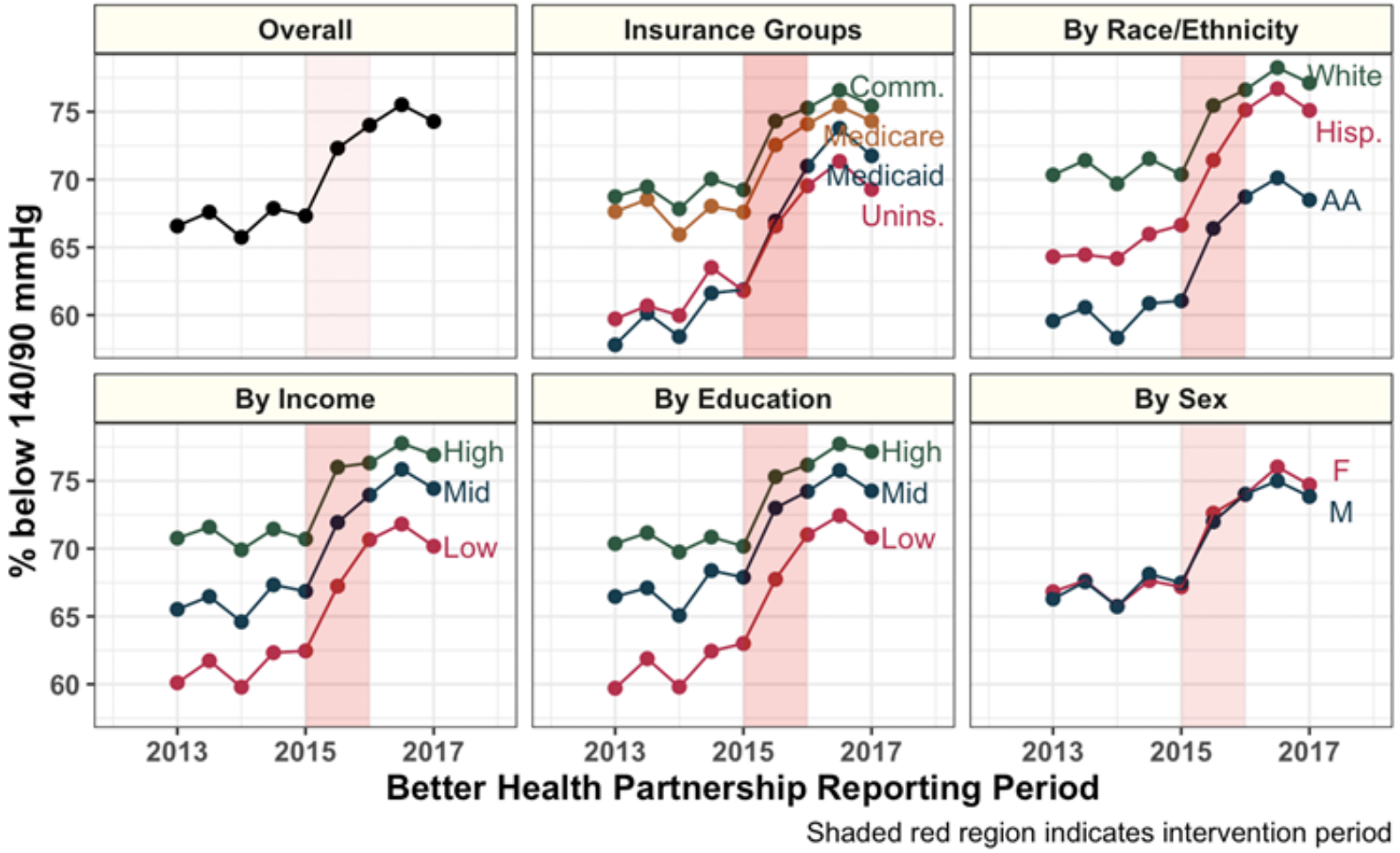
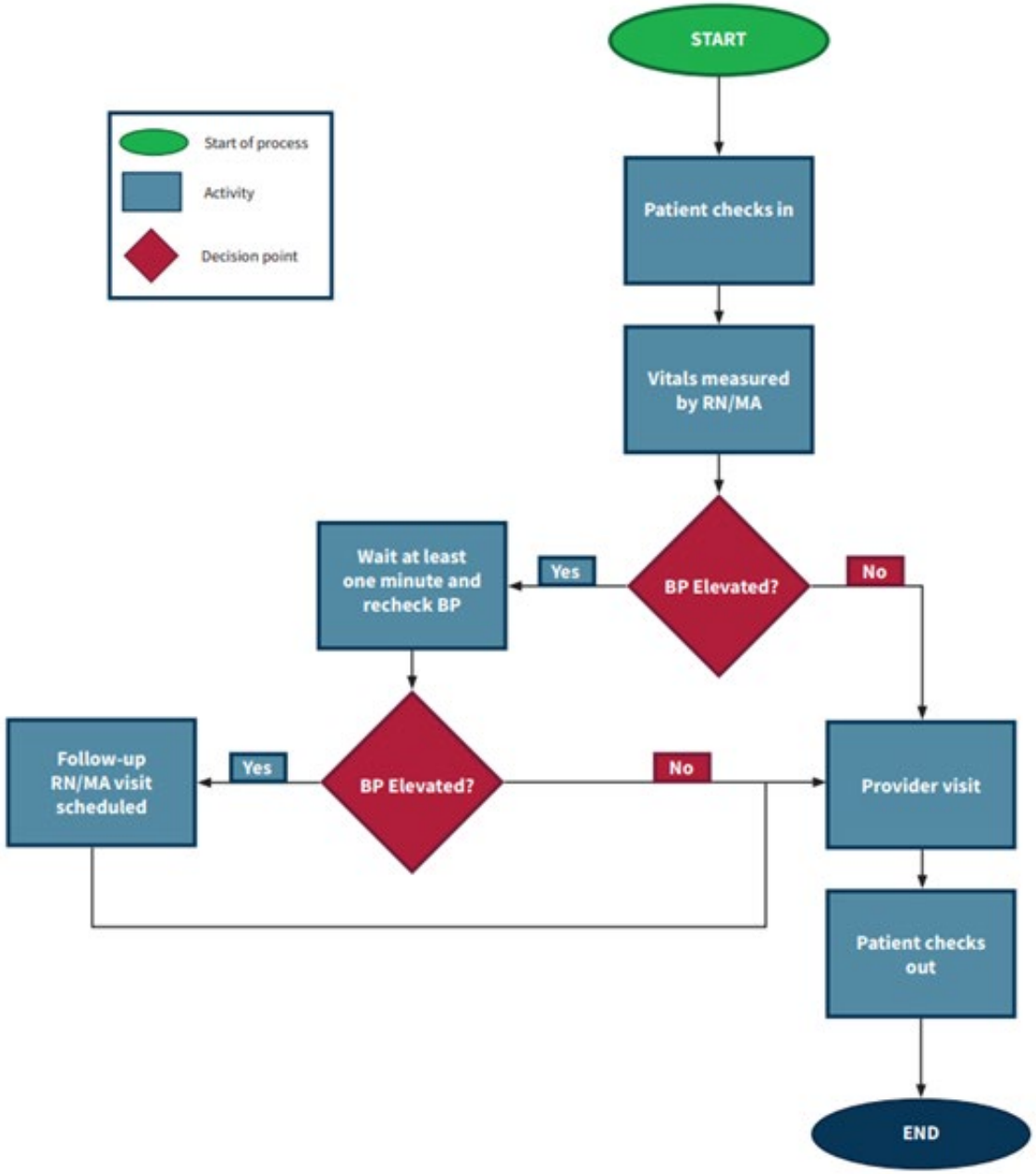
Jaffe MG, Lee GA, Young JD, Sidney S, Go AS. Improved blood pressure control associated with a large-scale hypertension program. JAMA. 2013 Aug 21;310(7):699-705. doi: 10.1001/jama.2013.108769. PMID: 23989679; PMCID: PMC4270203.

Better Health Partnership Blood Pressure Control Improvement Overall and by Subgroup



Bolen SD, Love TE, Einstadter D, Lever J, Lewis S, Persaud H, Fiegl J, Liu R, Ali-Matlock W, Bar-Shain D, Caron A, Misak J, Wagner T, Kauffman E, Cook L, Hebert C, White S, Kobaivanova N, Cebul R. Improving Regional Blood Pressure Control: a Positive Deviance Tiered Intensity Approach. J Gen Intern Med. 2021 Jun;36(6):1591-1597. doi: 10.1007/s11606-020-06480-z. Epub 2021 Jan 26. PMID: 33501526; PMCID: PMC8175516.



Example Process Map for Timely Followup of HTN

Barriers to Scheduling Timely Followup

- What barriers to scheduling timely followup do you believe will arise?
- What ideas do you have to address these barriers?

(Please unmute OR chat in your response)

QI Tool to Address Barriers: Short Form Failure Mode Effects Analysis

1. List high-level process steps

What Can Go Wrong?	High Level Process Step	How Might We Improve?
	Need for Follow Up Determined	
	Order Written	
	Scheduling Team Shares Options	
	Patient Selects Appointment Date/Time	
	Appointment Reminder(s) Sent	
	Patient Travels to Appointment	
	Patient Arrives at Follow Up Appointment	

Slide credited to Christopher R. Jordan, LLC

Short Form Failure Mode Effects Analysis

2. Known or potential types of process step failures **What Can Go Wrong?**	1. List high-level process steps **High Level Process Step**	3. Known or potential methods to mitigate failures **How Might We Improve?**
Competing demands at the visit – unrecognized HTN Repeat BP not done	**Need for Follow Up Determined**	Standardize process for ensuring BP reading available for visit Staff automatically identifies patients needing repeat BP or patients that had elevated BP reading at previous visit but no HTN diagnosis
Provider forgets to write order for followup	**Order Written**	Have staff automatically schedule a HTN follow-up visit based on last BP
No appointment availability in <35 days with provider Patient gets telemedicine appt scheduled but no home blood pressures to share for med changes	**Scheduling Team Shares Options And Provides Instructions**	Establish staff-led BP visits Pend order for home BP monitor if patient does not have one Standard instructions on checking BP
	Patient Selects Appointment Date/Time	
	Appointment Reminder(s) Sent	
No transportation set up to get to clinic	**Patient Travels to Appointment**	Same day transportation assistance; consider telehealth visit
	Patient Arrives at Follow Up Appointment	

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Slide credited to Christopher R. Jordan, LLC

Tips for Traps in Scheduling Timely Follow-up

A. **Insufficient staff time**: No time to conduct follow-up HTN visits
   - Start small, use templates, train 1-2 people and monitor

B. **Insufficient provider availability**: Thinking outside the box
   - Can support staff be trained to assist and lead a visit?
   - Asynchronous communication: Phone messages to reduce visit interruption from staff-led visits

C. **Insufficient personnel**: Start small, use templates for efficiency, workflow redesign

D. **Reluctant patients**
   - Share scripting for staff to use with patients to explain the importance of followup

E. **Patient barriers**: Social work; Payer partnerships; Phone/telemedicine options

F. **Scheduling**: May need to change scheduling templates

G. **Provider barriers (e.g., patients won't follow-up; no evidence for sooner follow-up)**: Inform providers around rationale/share slides; use PDSAs to test concerns; test first with providers who are interested

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Cardiovascular Visit Template

Clinic Documentation Tool for Electronic Health Records

Cardiovascular Health Clinic: _____

Follow up visit number (up to 3 visits and then back to provider):_____

1. BP Readings from Last 4 Encounters:
   [BP readings automatically brought into note here]
2. BP Medication taken today: {YES/NO:400258}
3. BP Medication brought to visit: {YES/NO:400258}
4. Can name blood pressure medications: {YES/NO:400258}
5. Any recent BP medication changes: {YES/NO:400258}
6. What time is BP medication taken:
   A. Is this correct: {YES/NO:400258}
7. How many missed doses in the past week of BP meds:
8. If taking a cholesterol medication, how many missed doses in the past week?_____
9. [If adherence is identified as an issue, discuss barriers to taking medications (timing, side effects, social situations, etc.) and establish an action plan.]
10. Any side effects or new symptoms since last visit: (describe)

    _____

11. Any over the counter (OTC) cold, allergy, respiratory medications: {YES/NO:400258}

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Cardiovascular Visit Template Continued

12. If you have sleep apnea are you using your Continuous Positive Airway Pressure (CPAP) nightly: {YES/NO:400258}

13. Do you have a home BP monitor to check your BP: {YES/NO:400258}
    [If no, pend order for home BP monitor for provider to sign]

14. If brought to clinic, was it checked to see if it is accurate: {YES/NO:400258}
    A. Was it accurate: {YES/NO:400258}

15. Do you drink beer, wine, or any other form of alcohol: YES/NO:400258}
    A. How many drinks in the last 24 hours: _____

Tobacco follow up questions – limit to current tobacco users

[Check back in even if they were not interested in quitting at the first session]

1. Since your last visit, has there been a change in your tobacco use?
   YES / NO

2. If yes, what changed?
   - Quit – congratulations; info on ongoing supports to prevent slips.
   - Cut down – congratulations;
   - Some other positive change (reduction, restricting when / where smoking)
   - Smoking more

SKIP to Q7 if you offered smoking cessation referral at the last visit

3. If still smoking, are you interested in quitting in the next month? {YES/NO:400258}
   [**If last time they did not want assistance, you might say something like: "Last time we talked, you were not interested in assistance with quitting. Would you like assistance now?]

4. If yes, would you like me to connect you with someone who can assist you in quitting? {YES/NO:400258}

5. If yes to Q4, was patient referred to smoking cessation resource? {YES/NO:400258}
   [Can refer to Ohio Quitline via web referral at https://ohio.quitlogix.org/en-US/Just-Looking/Health-Professional/How-to-Refer-Patients. The quit line will then reach out to the patient and provide counseling and nicotine replacement]

6. Tobacco cessation medications can increase your likelihood of quitting by 2-3 times. Are you interested in using medications to help quit? {YES/NO:400258}
   [Assist by pending order or note to provider to order nicotine patch and gum, chantix, or wellbutrin for clinician.]

Cardiovascular Visit Template Continued

Assessment:

1. Has the blood pressure goal been met: {YES/NO/NA:400258}
2. Has the smoking goal been met: {YES/NO/NA:400258}

Plan:

_____

Medication changes (if applicable):

_____

Education given (especially lifestyle change such as DASH and low salt diet):

_____

(Describe and print to After Visit Summary)

Referred to Dietitian: {YES/NO:400258}

Follow up appointment with_____in_____weeks.

Patient agrees with plan: {YES/NO:400258}

Basic metabolic panel today: {YES/NO:400258}
[If provider newly started or increased a medication which could change potassium or kidney function, remind patient to obtain lab or ask provider to order lab if not already done]

Consulted with Dr.: _____

Guidelines for follow-up:

- If BP is at goal: See PCP in 3 months
- If BP remains high: See RN in 4 weeks
- After third visit with RN, if BP is still high, follow up with PCP in 2-4 weeks

Website Toolkit Resources

Timely Follow Up (hearthealthyohio.org)

Timely Follow Up

Timely follow-up is important for those with elevated cardiovascular risk. For patients with elevated blood pressure, at least monthly follow-up is recommended until the blood pressure is controlled. For smokers, routine follow-up is also recommended for patients interested in quitting. Below are resources to assist primary care teams in implementing a process to ensure every patient receives an opportunity for timely follow-up.

The process maps and flowchart provide examples of how to integrate this into current workflow (Resources 1 and 2). Please review and modify the staff-led cardiovascular visit template (Resource 3) to fit your practice. Resource 4 can be printed for use by staff performing the cardiovascular focused follow-up visit to remind them about common medication side effects and when to draw labs on selected patients.

Resource 1: Process Map for Blood Pressure Follow-up

Resource 2: Tobacco Cessation Flowchart Using the 5As Model

Resource 3: Cardiovascular Health Follow-up Visit Template

Resource 4: Medication Reference Table for Staff Led Visit

HEART HEALTHY OHIO INITIATIVE

Treatment Algorithms (Under Appropriate and Timely Treatment on website)

Medication Management

Hypertension Resources

We encourage your team to review the treatment algorithms (Resources 1-2) and choose or modify one to use in your practice. This is also a good time to review and discuss your blood pressure treatment targets (Resources 3-5).

Resource 1: Cardi-OH Hypertension Drug Treatment Algorithm

Resource 2: Cardi-OH Hypertension Change Package Algorithm

Resource 3: Cardi-OH Blood Pressure Targets: Talking with Your Team

Resource 4: Cardi-OH Long-Acting, Low-Cost Medications to Achieve Blood Pressure Targets: Evidence for Chlorthalidone, Amlodipine, and Spironolactone

Resource 5: Cardi-OH Safety and Tolerability of Lower Blood Pressure Targets

Smoking Cessation Resources

We encourage primary care teams to review this frequently asked questions document which provides practical tips on referral and medications for smoking cessation.

Resource 1: Cardi-OH 2020 Smoking Cessation Guidelines FAQs

HEART HEALTHY OHIO INITIATIVE

Summary

- Team-based care can assist us in monthly cardiovascular followup and provide opportunities to address other care gaps
- Standardized visit templates ensure focus on critical aspects of HTN management and smoking cessation efforts
- Treatment algorithms can support medication intensification during followup
- Process maps for timely follow-up are essential to ensure everyone has the opportunity for frequent high-quality care when needed
- Remember to recognize your own and your team members' hard work

HEART HEALTHY OHIO INITIATIVE

Teams in Action

QI Coaches

QIP Clinics

Quote

- "Real change, enduring change, happens one step at a time."
  —**Ruth Bader Ginsburg**

Poll

Would your practice team be interested in receiving a Heart Healthy Ohio pin?

- Yes
- No
- N/A

Next Steps

- Continue to submit EHR data monthly (1st Monday of the month; next due October 3rd)
- Review and modify the treatment algorithm and cardiovascular visit template when beginning the timely followup process
- Continue to meet with your QI coach monthly
- Remember to engage a patient and obtain their feedback
- Payer collaboration meetings are ongoing for those interested
- Next webinar December 9th

Learn more & access resources at https://hearthealthyohio.org/